IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

CAREMARKPCS HEALTH, L.P., a Delaware Limited Partnership,	)	
Plaintiff,	)	Case No.
vs.	)	JUDGE FILIP MAGISTRATE JUDGE KEYS
WALGREEN CO., an Illinois Corporation,	)	CEM
Defendant.	)	

EXHIBITS IN SUPPORT OF PLAINTIFF'S VERIFIED COMPLAINT FOR INJUNCTIVE AND OTHER RELIEF

EXHIBIT	DESCRIPTION
1	Provider Agreement between PCS Health Systems, Inc. and Walgreens, dated January 3, 2001
2	Notice to Retail Pharmacies regarding the integration of Caremark Rx, Inc. and Advance PCS
3	Caremark Provider Manual
4	Federal Express delivery confirmation, June 1, 2007
5	Walgreen's Termination Notices to Caremark, October 29, 2007

Exhibit 1

PCS HEALTH SYSTEMS, INC.
PROVIDER AGREEMENT

This Provider Agreement (the "Agreement") is entered into between PCS Health Systems, Inc., a Delaware corporation ("PCS"), and the undersigned provider ("Provider") and shall become effective, and binding on the Provider, as of the date PCS accepts this Agreement by executing a Network and Plan Enrollment Form (the "Enrollment Form") that has been executed and submitted by Provider (the "Effective Date").

RECITALS

A. PCS offers pharmacy benefit management services to its customers and has established a remote electronic claims adjudication and processing system known as the RECAP® System for verifying and processing claims and furnishing other related administrative and clinical services through a nationwide system of pharmacies and other facilities for its pharmacy benefit management services.

B. PCS' customers sponsor, administer or otherwise participate in prescription benefit and related programs.

C. Provider wishes to provide pharmacy and related services in connection with PCS' customers' programs.

AGREEMENTS:

For valuable consideration, the receipt and sufficiency of which are acknowledged, PCS and Provider agree as follows:

1. Definition Schedule.

1.1 **Definitions.** For purposes of this Agreement, unless otherwise defined herein, the terms listed in the attached Schedule of Terms shall have the meanings in that schedule.

1.2 **Schedules.** References to other schedules mean the schedule in effect from time to time.

1.3 **Amendments.** From time to time PCS may amend this Agreement, the Schedules to which this Agreement refers, the PCS Manual or On-Line Info by giving notice to Provider of the terms of the amendment and specifying the date the amendment becomes effective, which shall not be less than thirty (30) days after the notice. Provider may object to any amendments by giving written notice thereof to PCS prior to the expiration of the thirty (30) day period. In this event, if the parties cannot agree on an appropriate amendment, this Agreement shall terminate at the end of the thirty (30) day period. If Provider does not object within the thirty (30) day period, the amendment shall be effective as of the specified date.

2. Responsibilities and Rights of Provider.

2.1 **Services and Standards.** Provider will render or cause to be rendered to all Eligible Persons the Pharmacy Services to which the Eligible Person is entitled in accordance with the Prescriber's directions, the applicable Plan, the PCS Documents and applicable Law (including, without limitation, licensing, certification, and continuing education requirements). Provider and its employees and agents, in providing Pharmacy Services under this Agreement, will exercise their own professional judgment, to the best of their ability, on all applicable questions.

2.2 **Verification of Eligibility.** Provider will require each person requesting Pharmacy Services under a Plan to verify that he or she is an Eligible Person.

2.3 **Prior Authorization.** For prescriptions requiring a "prior authorization" as indicated in the RECAP® System, Provider will inform the Eligible Person that prior authorization from the Plan Sponsor is required.

2.4 **Collection of Copay.** With respect to each Covered Item submitted through the RECAP® System, Provider will collect the Copay as indicated in the RECAP® System from the Eligible Person and Provider will not waive, discount, reduce or increase the Copay indicated in the RECAP® System without the prior written consent of the Plan Sponsor and acting in compliance with applicable Law.

2.5 **Documentation; Signature Log.** Provider will maintain a signature log at each of its pharmacy locations listing the Plan Sponsor, prescription order number, and date of receipt, and require Eligible Person or representative who receives a Covered Item to sign the log. If requested by Provider, PCS will review other comparable systems or logs which provide documentation of receipt and compliance with this provision; provided, however, that acceptance by PCS of an alternate system or changes to such system, must be in writing.

2.6 **Record Retention**. PCS and Provider will maintain for a minimum of three years (or longer if required by applicable Law) after the respective record is created, in original form, fiche or on electronic media, the claims and claim forms supporting the invoices and other records sufficient to verify Covered Items dispensed, claims processed, payments made to Provider, and documentation and logs. Notwithstanding the foregoing, Provider shall keep hard copies of prescriptions, and updates thereto, as required by applicable Law and the PCS Manual.

2.7 **Electronic Communication**. Provider agrees to maintain the capability to send, receive, and display electronic messages to and from PCS in accordance with (i) NCPDP standards, including such new standards from time to time, and (ii) the PCS Documents and program requirements. Provider shall receive and display all messages necessary to participate in PCS claims processing and pharmaceutical services programs. Provider shall take appropriate professional action upon receipt of such messages. Provider will use software that has been certified by PCS as meeting both the NCPDP standards and PCS program requirements.

2.8 **Compliance with Drug Formulary**. Provider will comply with the PCS or applicable Plan Sponsor Formulary unless Provider is (a) prohibited by state law; or (b) otherwise directed by PCS via POS; or (c) pharmacist deems such compliance contrary to his professional judgement.

2.9 **Limitation on Collection**. Provider agrees that in no event, including, without limitation, non-payment or bankruptcy by a Plan, will Provider seek compensation in any manner from an Eligible Person for Pharmacy Services with respect to a Covered Item provided under this Agreement. This provision does not prohibit Provider from collecting the applicable Copay, coinsurance or deductible amounts that are indicated in the RECAP® System, which amount Provider is obligated to collect and agrees not to waive without the prior written consent of the Plan Sponsor and acting in compliance with applicable Law. Further, these provisions do not prohibit the Provider from collecting fees for items that are not Covered Items. Provider also agrees to be bound by any other applicable Law regarding limitation of collection, including, without limitation, any provisions set forth in the Schedule of Provisions Applicable to Providers in Certain States attached hereto.

2.10 **Maintenance of a PCS RECAP® Terminal**. If Provider has a PCS RECAP® terminal, Provider agrees to permit maintenance personnel selected by PCS full access to all PCS RECAP® terminals to make routine service checks and any necessary repairs. PCS, at its expense, will use its reasonable good faith efforts to arrange for maintenance of the terminal at Provider's site, during Provider's regular business hours, or at PCS' or its designated representatives' site for repair or replacement. PCS shall not be liable for delays in repairing the terminal or for failure of maintenance personnel to properly perform their duties.

2.11 **Insurance**. Provider will maintain general and professional liability coverage in such forms and amounts as are reasonable for the industry and for a provider of Pharmacy Services of the type and size of Provider which shall in no event be less than required by applicable Law. Provider will provide PCS with a copy of all professional liability insurance policies in effect from time to time upon request.

2.12 **Credentialing**. Provider agrees to provide PCS with the necessary information required from time to time to complete PCS' credentialing programs.

2.13 **QUANTUM Alert®**. Provider acknowledges and agrees that the information generated in connection with QUANTUM Alert® is intended as an economical supplement to, and not a substitute for, the knowledge, expertise, skill, and judgment of Prescribers and pharmacists, including Provider and its employees and agents. Provider and its individual employees and agents are responsible for acting or not acting upon information generated and transmitted through QUANTUM Alert® and for performing Pharmacy Services in each jurisdiction consistent with the scope of their respective licenses.

2.14 **Nondiscrimination**. Unless Provider's professional judgment dictates otherwise or Provider is being asked to provide Pharmacy Services to an Eligible Person covered by a Plan participating in the RECAP® Network, Provider must serve all Eligible Persons. Provider shall not serve only some Eligible Persons or provide only certain Covered Items to Eligible Persons.

2.15 **Eligible Persons Complaint Procedures**. Provider shall cooperate with the administration of complaints by Eligible Persons. Provider shall make reasonable efforts to resolve all complaints in an informal process and keep, where reasonable given the nature of the compliant, appropriate written records of events and actions surrounding complaints that are not resolved to the Eligible Person's satisfaction.

2.16 **Regulations related to Governmental Plan Sponsors**. The following clauses from the Federal Acquisition Regulations ("FAR") are hereby incorporated by reference to implement certain federal policies to the extent applicable to the Provider's business: (I) FAR 52.203-12, "Limitation on Payments to Influence Certain Federal Transactions (31 U.S.C.§ 1352)," (ii) FAR 52.222-26, "Equal Opportunity (E.O. 11246)," (iii) FAR 52.222-35, "Affirmative Action for Special Disabled and Vietnam Era Veterans (38 U.S.C. § 2012(a))" and (iv) FAR 52.222-36, "Affirmative Action for Handicapped Workers (29 U.S.C.§ 793)."

2.17 Rebate Programs. PCS shall have the right to submit all prescriptions relating to this Agreement to manufacturers in connection with PCS' manufacturer rebate programs and any similar programs (collectively, "PCS Rebate Programs"). Provider may submit any of the prescriptions relating to this Agreement to any manufacturer for the purposes of receiving rebates, discounts or the like, to the extent that it does not prohibit PCS from enforcing PCS' manufacturing Rebate Programs and any similar program, or adversely affect PCS' ability to receive rebates under the PCS Rebate Program.

3. Transmission of Claims to PCS for Reimbursement.

Provider will submit claims for payment in accordance with the PCS Documents and the following:

3.1 RECAP® Submission. Provider will submit on-line claims through the RECAP® System within ninety (90) days from the date of fill. As to those claims, Provider will have the transmission capability to make on-line claim reversals and will reverse claims within (90) days from date of fill when appropriate. All claims that have previously been submitted and reversed must be resubmitted through the RECAP System within fourteen (14) days from the date of fill. If any claim is rejected, or if additional information is required for further processing by PCS, Provider must resubmit the claim to PCS for payment within ninety (90) days from the date claim was originally submitted.

3.2 Other Submissions. Upon PCS' prior approval, Provider may submit any claims not submitted through the RECAP® System to PCS (whether in a paper, tape or electronic format) within twelve (12) months of the date of fill. In the case of a PCS National Network or any Plan that may reimburse Provider at the Usual and Customary Price, Provider shall not be permitted to submit a claim in a format that does not provide for the transmission of Usual and Customary Price. Provider shall not be permitted to submit claims in a format that is not authorized by the Plan Sponsor.

3.3 Information. Provider will transmit with each claim the information requested by this Agreement, the PCS Documents or the RECAP® instructions. Each claim submitted by Provider through the RECAP® System shall constitute a representation by Provider to PCS that Pharmacy Services were provided to the Eligible Person and the information submitted is accurate and complete.

4. Participation in the PCS National Networks, Plan Sponsor Networks and RECAP® Network; Applicable Reimbursement Rates to Provider.

4.1 Participation in the PCS National Networks, Plan Sponsor Networks and the RECAP® Networks. Provider shall participate in the PCS National Networks and Plans selected by Provider on the Enrollment Form (or any subsequent enrollment form or addendum that PCS may provide) and those Plan Sponsor Networks that Provider participated on the date prior to the Effective Date. "Plan Sponsor Networks" means the networks established by PCS on behalf of its Plan Sponsors pursuant to (i) this Agreement, an addendum hereto or an Enrollment Form or any subsequent enrollment form, each as may be amended from time to time in accordance with Section 1.3, or (ii) a written agreement, an addendum thereto or a written enrollment form, each as may have been amended from time to time, that was executed by Provider prior to this Agreement (collectively, "Prior Agreements"). Plan Sponsor Networks do not include PCS National Networks. In addition, Provider shall participate in any Plan participating in the RECAP® Network by submitting a claim as provided for in Section 3. For certain PCS National Networks and Plan Sponsor Networks, PCS may allow Provider to participate in such Network by submitting a claim as provided for in Section 3. Notwithstanding any Prior Agreements, this Agreement shall apply to all transactions under any Network or Plan. Provider agrees to provide Pharmacy Services to all Plans participating in a PCS National Network.

4.2 Termination of Network Participation. Except as otherwise may be required with respect to a specific Network or Plan participating in the RECAP® Network, Provider may terminate participation in any Network or any Plan participating in the RECAP® Network by giving PCS ten (10) days' prior written notice specifying the date of termination and the names of the Network(s) and Plan(s) in which Provider will no longer participate. Absent the prior written consent of PCS, Provider may not elect to participate in a Network or Plan that is part of the RECAP® Network for thirty (30) days following Provider's termination of participation in such Network or Plan.

4.3 Reimbursement to Provider:

4.3.1 PCS National Networks. Claims submitted for a Plan participating in a PCS National Network will be reimbursed at the lower of (i) AWP less the applicable Discount (as defined in the Enrollment Form) plus the applicable Dispensing Fee (as defined in the Enrollment Form) less the applicable Copay, (ii) MAC plus the applicable Dispensing Fee less the applicable Copay, (iii) Ingredient Cost submitted by Provider plus the applicable Dispensing Fee less the applicable Copay or (iv) Usual and Customary Price less the applicable Copay.

4.3.2 Plan Sponsor Networks. Claims submitted for a Plan participating in a Plan Sponsor Network will be reimbursed at the lower of (i) AWP less the applicable Plan Sponsor AWP Discount plus the applicable Plan Sponsor Dispensing Fee less the applicable Copay, (ii) MAC plus the applicable Plan Sponsor Dispensing Fee less the applicable Copay, (iii) Ingredient Cost submitted by Provider plus the applicable Plan Sponsor Dispensing Fee less the applicable Copay or (iv) Usual and Customary Price less the applicable Copay. The "Plan Sponsor AWP Discount" shall mean the AWP percentage discount that (i) with respect to Plan Sponsor Networks established after the date of this Agreement, is set forth in this Agreement, an addendum hereto, the Enrollment Form or any subsequent enrollment form, each as may be amended from time to time, or (ii) with respect to Plan Sponsor Networks that were established prior to this Agreement, is set forth the applicable Prior Agreement. A Plan Sponsor AWP Discount contained in a Prior Agreement, may hereafter be amended as provided for in

Section1.3. The "Plan Sponsor Dispensing Fee" shall mean the dispensing fee that (i) with respect to Plan Sponsor Networks established after the date of this Agreement, is set forth in this Agreement, an addendum hereto, the Enrollment Form or any subsequent enrollment form, each as may be amended from time to time, or (ii) with respect to Plan Sponsor Networks that were established prior to this Agreement, is set forth in the applicable Prior Agreement. A Plan Sponsor Dispensing Fee contained in a Prior Agreement may hereafter be amended as provided for in Section 1.3. Except as otherwise provided in Section 4.1, if Provider has not executed and delivered to PCS one of the above described documents with respect to a specific Plan Sponsor Network, claims submitted for such a Plan will be reimbursed at the then current reimbursement rate for the Plan Sponsor Network as indicated in the RECAP® System as to each transaction.

4.3.3 RECAP® Network. Claims submitted for a Plan participating in the RECAP® Network will be reimbursed at the then current reimbursement rate for the Plan as indicated in the RECAP® System as to each transaction.

4.3.4 Non-RECAP® Submissions. Claims submitted by means other than RECAP® System will be reimbursed in accordance with the applicable reimbursement methodology provided for above. Provider acknowledges that claims that are not adjudicated through the RECAP® System and verified as a Covered Item may not be reimbursed by PCS on behalf of one of its Plan Sponsors due to the nonpayable nature of the claim (e.g., the individual is not an Eligible Person or the dispensed item is not a Covered Item).

4.3.5 Taxes. If Provider requests reimbursements from a Plan Sponsor related to taxes that are imposed by applicable Law on the Pharmacy Services or the Covered Items, Provider shall transmit the applicable tax amount through the RECAP® System. If there is a discrepancy between the amount indicated by PCS in the corresponding RECAP® System response and the amount originally submitted by Provider, the amount indicated by PCS in the RECAP® System response shall govern.

4.4 PCS' Reimbursement Obligations. PCS is not obligated to reimburse Provider, on behalf of a Plan Sponsor, and may, if necessary, chargeback Provider, on behalf of a Plan Sponsor, with respect to a given claim if Provider has breached the terms of this Agreement or the PCS Documents with respect to such claim.

4.5 Timing of Reimbursement; Reports. PCS will process Provider's claims and pay Provider in accordance with PCS' current schedule of processing and payment and will provide Provider with a report showing the record of all claims submitted, processed and paid in each processing cycle. Claims submitted by Provider for Covered Items will be processed no less than twice monthly and paid within (30) days of PCS' receipt of funds from the Plan Sponsor(s).

4.6 Correction of Errors. Except as otherwise provided in this Agreement (including, without limitation, Section 4.7), PCS, on behalf of the Plan Sponsor, will pay to the Provider any underpayment. Additionally, Provider will repay to PCS, for the benefit of the applicable Plan Sponsor, any overpayments made by PCS to Provider, including overpayments due to errors contained in claims and inaccurate submission of claims to PCS irrespective of when such overpayment error are discovered.

4.7 Time for Objecting to Report. If Provider fails to advise of any alleged error, miscalculation, discrepancy or basis for questioning the correctness of any claim within twelve (12) months after receiving the report for a cycle, Provider will be deemed to have confirmed the accuracy of the processing of claims as set forth in that report for that cycle. This provision shall not apply with respect to any overpayments made to Provider by PCS on behalf of a Plan Sponsor that come to PCS' attention in connection with its (or the Plan Sponsor's) auditing efforts.

4.8 Fees to be Paid to PCS by Provider.

Enrollment Fees. PCS will not charge Provider enrollment fees to enable Provider to participate in one or more of the Networks as set forth in the PCS Provider Manual.

Transmission and Maintenance Fees; Taxes. Provider may telecommunicate claims to PCS through Provider's computer system or through a RECAP® terminal which may be leased or purchased from PCS. Provider may also submit claims on paper or in batch format. Provider will pay PCS transaction charges per claim verified as a Covered Item according to the Schedule of Transmission and Maintenance Fees depending on the method of transmission and the equipment used. PCS may deduct the appropriate fees from amounts otherwise payable to Provider during each payment cycle. Provider is responsible for all applicable taxes. Transmission fees and maintenance fees are set forth in the Schedule of Transmission and Maintenance Fees attached hereto.

5. Responsibilities and Rights of PCS.

5.1 PCS Limited Agent of Provider; Nonpayment. PCS will pay Provider and Provider will accept the reimbursement for each Covered Item dispensed to an Eligible Person and which is eligible for payment under the terms of this Agreement. If PCS has not received funding from a Plan Sponsor, then PCS has no obligation to pay Provider, nor will PCS incur any such payment liability whatsoever until such a time as a Plan Sponsor makes funds available.

5.2 Inspection Rights; Discrepant Claims. PCS may inspect all records of Provider relating to this Agreement including, but not limited to, original signed Prescriber's orders, telephoned Prescriber's orders, signature logs and computer records. PCS may also inspect such other documents and items that reasonably relate to Provider's compliance with the PCS Documents, including, without limitation, Section 2.7. Amounts paid to Provider in connection with Claims that are not documented in accordance with the PCS Documents and that are not validated by Provider within thirty (30) days after written request by PCS, shall become due and owing to PCS by Provider at the expiration of such thirty (30) day period. PCS may notify the Plan Sponsor of any discrepancies with respect to claims under its plan. PCS shall give Provider reasonable prior notice of any inspections to be performed by PCS pursuant to this Section 5.2 except where PCS reasonably determines that giving such notice may adversely impact PCS' rights under this Agreement or any Plan Sponsor's rights. Provider agrees to cooperate in good faith with PCS to accommodate audits scheduled by PCS.

5.3 Help Desk. To assist in resolving Provider's questions or issues, the PCS Pharmacy Help Desk will provide access to Provider to both its Voice Response System and PCS representatives. The PCS representatives shall be available during hours set by PCS from time to time. The PCS Pharmacy Help Desk will use its reasonable efforts to assist Provider while the Eligible Person is still at Provider. During PCS' normal business hours, a licensed pharmacist will be available to answer questions beyond the scope of the PCS Pharmacy Help Desk representatives' knowledge; provided, however, such licensed pharmacist will not provide any professional advice with respect to the provision of Pharmacy Services.

5.4 Software Certification. PCS will provide software technical support to assist Provider in complying with PCS requirements for transmitting claims through the RECAP® System. PCS will certify software that meets PCS requirements. If applicable, Provider hereby authorizes PCS to disclose to a software vendor (i) that Provider is using such vendor's software and (ii) statistical information related to claims processed by Provider through vendor's software.

5.5 Court Orders, Subpoenas or Governmental Requests. If PCS receives a court order, subpoena or governmental request relating solely to Provider, PCS may comply with such order, subpoena or request and Provider shall indemnify and hold harmless PCS for, from, and against any and all costs (including reasonable attorneys' fees), losses, damages or other expenses PCS may suffer or incur in connection with the responding to such order, subpoena or request.

5.6 Changes to PCS' Proprietary MAC List. PCS may, in its reasonable judgment, make adjustments to its proprietary MAC List. If PCS shall make changes to its proprietary MAC List, PCS shall use reasonable efforts to notify (via facsimile) Provider of such changes thirty (30) days in advance of such change. Claims processed in connection with a PCS National Network shall utilize PCS' proprietary MAC List unless PCS otherwise notifies Provider.

6. Intellectual Property Rights; Confidentiality

6.1 Advertising and Trademarks. PCS retains exclusive rights to, among others, the names "PCS Health Systems, Inc.," "PCS," "RECAP®," "QUANTUM Alert®," together with any distinctive trademarks and service marks that have been used by PCS or may be adopted or used by PCS in the future. Provider may not advertise or use any name, symbol, or trademark of PCS in any advertising other than as specifically permitted in the PCS Documents without the prior written consent of PCS. PCS may (i) use the name and address(es) of Provider in the National Directory, informational brochures or other publications provided to Plan Sponsors and Eligible Persons, (ii) use information regarding Provider's services that is provided to PCS by Provider in publications provided to Plan Sponsors and Eligible Persons and (iii) provide Plan Sponsors with Provider's credentialing information. Upon termination of this Agreement for any reason, Provider will immediately discontinue the use and advertising of, among others, any name, symbol or trademark referring to the Plans, "PCS Health Systems, Inc.," "PCS," "RECAP®," "QUANTUM Alert®," together with any distinctive trademarks and service marks that have been used by PCS or may be adopted or used by PCS in the future.

6.2 Proprietary Rights. Provider has no right to use or reproduce any data, work, compilation, computer program, manual, process or invention obtained from or owned by PCS or any Plan Sponsor, including, without limitation PCS' proprietary MAC list or any MAC list used on behalf of a Plan Sponsor, except in connection with and as expressly provided by this Agreement and then only during the term of this Agreement. Provider agrees that the compilations of information contained in the RECAP® System and any prior and future versions of that System by any names and any copyright rights to such compilations are the property of PCS and Provider agrees not claim any right, title or interest in such compilations arising from this Agreement. Subject to applicable Law, Provider will provide to PCS any and all information reasonably available to it that PCS needs to perform its services and to conduct benefit and drug utilization review. Subject to any restrictions imposed by applicable Law, either party has the right to use, reproduce and adapt all information obtained from Provider in any manner it deems appropriate, , provided such use is not in violation of applicable Law.

6.3 Confidentiality. Any information or data supplied by PCS or Plan Sponsor to Provider under this Agreement, including, without limitation, PCS' proprietary MAC list or any MAC list used on behalf of a Plan Sponsor, must be maintained in confidence and may not be sold, assigned, transferred, or given to any third party. This information may be disclosed to employees, agents, or contractors of Provider only to the extent necessary for them to perform their duties and then only if they have undertaken like obligations of confidentiality. No information or data supplied by PCS to Provider may be quoted or attributed to Provider or PCS without the prior written consent of PCS. PCS and Provider must use all necessary security procedures sufficient to insure that all data transmissions are authorized and to protect their business records and data from improper access.

6.4 **Remedies**. Provider acknowledges that any unauthorized disclosure or use of PCS proprietary information would cause PCS immediate and irreparable injury or loss. Accordingly, should Provider fail to abide by this Section 6, PCS shall be entitled to specific performance including immediate issuance of a temporary restraining order or preliminary injunction enforcing this Agreement, and to judgment for damages (including attorneys' fees) caused by the breach and to all other remedies provided by this Agreement and applicable Law.

7. Limitation of Liability; Indemnity and Force Majeure.

7.1 **Limitation on Liability**. PCS shall not be liable to Provider for any claim, injury, demand or judgment based upon contract, tort, or other grounds (including warranty of merchantability) arising out of the sale, compounding, dispensing, manufacturing, or use of any drug or device dispensed by or any Pharmacy Services provided by Provider under this Agreement. In no event is either party liable to the other party for indirect, consequential or special damages of any nature (even if informed of their possibility), lost profits or savings, punitive damages, injury to reputation or loss of customers or business.

7.2 **Indemnification.** Provider agrees to indemnify and hold PCS and Plan Sponsors, and their respective shareholders, directors, employees, agents and representatives free and harmless for, from and against any and all liabilities, losses, settlements, claims, demands, and expenses of any kind (including attorneys' fees and costs), that may result or arise out of: (i) any actual or alleged malpractice, negligence or misconduct of Provider in the performance or omission of any act or responsibility assumed by Provider under this Agreement, or (ii) the sale, compounding, dispensing, failure to sell, manufacturing or use of a drug or device dispensed by Provider of Pharmacy Service provided by Provider under this Agreement.

7.3 **Force Majeure**. PCS and Provider shall be excused from performance under this Agreement to the extent that PCS or Provider, as the case may be, is prevented from performing hereunder, in whole or in part, as a result of causes beyond such affected party's reasonable control, including, acts of God, war, civil disturbance, court order, governmental intervention, a change in Law, third party nonperformance, failures or fluctuations in electrical power, heat, light, air conditioning or telecommunications equipment.

8. Term of Agreement; Termination and Certain Remedies.

8.1 **Term**. Unless earlier terminated in accordance with the provisions of this Agreement, the Agreement will begin on the Effective Date and will remain in effect for an initial term of one (1) year and will automatically renew for successive terms of one (1) year each.

8.2 **Termination Without Cause on Notice**. Either party may terminate this Agreement without cause upon ten (10) days' prior written notice to the other, provided, however, that if a particular Plan requires a longer notice period, this Agreement shall not terminate with respect to the affected Plan until the expiration of such longer period.

8.3 **Immediate Termination Rights**. If (i) unless otherwise precluded by Law, Provider shall make an assignment for the benefit of creditors, file a petition in bankruptcy (whether voluntary or involuntary), is adjudicated insolvent or bankrupt, a receiver or trustee is appointed with respect to a substantial part of its property or a proceeding is commenced against it which will substantially impair its ability to perform hereunder, (ii) any court, governmental or regulatory agency shall issue to Provider an order to cease and desist from providing Pharmacy Services, (iii) ownership of Provider is transferred to a new owner, or if the right to control the operation of the business of Provider is transferred to a different person or entity, (iv) a levy, writ of garnishment, attachment, execution or similar item is served upon Provider and not removed within ten (10) days from the date of service or (v) Provider fails to perform or breaches any term or provisions of the PCS Documents, PCS may terminate this Agreement effective upon notice to Provider. This termination right is in addition to any and all other rights and remedies that may be available to PCS under this Agreement or at law or equity.

8.4 **PCS' Rights in the Event of Termination**. In the event of a termination of this Agreement for any reason, PCS has the right to immediate possession of the PCS card imprinter, if furnished by PCS, the PCS RECAP® terminal, if furnished by PCS, the PCS Manual, On-Line Info and all other materials and supplies furnished by PCS to Provider.

8.5 **Provider Event of Default and PCS Remedy and Other PCS Rights**. In addition to the termination rights contained in this Section 8, if Provider fails to perform under this Agreement or breaches any provision of this Agreement, PCS shall have the right, upon notice to Provider to (i) suspend performance of any and all of PCS' obligations under or in connection with this Agreement, including, without limitation, PCS' obligation to process Claims using the RECAP® System, (ii) impose reasonable handling, investigation and improper use fees (including, without limitation, a fee to be charged for Provider failing to submit a Usual and Customary Price), or (iii) set off against any amounts owing to Provider under the PCS Documents (including amounts which are paid to PCS on behalf of a Plan Sponsor) or under any other agreement between PCS and Provider, any amounts required to be paid by PCS to Provider under the PCS Documents or any other agreement between PCS and Provider. Nothing in this Agreement shall limit, and the parties agree that in addition to the rights specified in this Section, PCS shall retain, any and all rights PCS may have at law, equity or under this Agreement.

8.6 **Survival of Certain Provisions**. Notwithstanding the termination of this Agreement, Sections 5.2, 6 and 7 and any obligations that arise prior to the termination of the Agreement shall survive such termination.

8.7 Notices. All notices provided for in this Agreement shall be delivered in person, sent by certified mail, delivered by air courier, or transmitted by facsimile and confirmed in writing (sent by air courier or certified mail) to a party at the address or facsimile number shown in this Agreement, or such other address or facsimile number as a party may notify the other party from time to time in accordance with this Agreement. All notices will be deemed received on the day received unless such day is not a business day, in which case such notice will be deemed to have been received on the first business day following receipt. Notices may also be transmitted electronically between parties provided that proper arrangements are made in advance to facilitate such communications and provide for their security and verification.

Notices to PCS must be addressed to:

PCS Health Systems, Inc.
Attn: Provider Enrollment
9501 East Shea Boulevard
Scottsdale, Arizona 85260-6719

Fax Number: (480) 661-3715

Notices to Provider must be addressed as set forth on the Enrollment Form.

9. Miscellaneous

9.1 Assignment. This Agreement may not without the prior written consent of PCS, which consent shall not be unreasonably withheld, be assigned by Provider to any other person or entity, and any attempted assignment will be void and of no force and effect.

9.2 Independent Contractor; Third Party Beneficiaries. The parties to this Agreement are to be considered independent contractors, and they shall have no other legal relationship under or in connection with this Agreement. Except for the indemnity provisions hereof, no term or provision of this Agreement is for the benefit of any person who is not a party hereto (including, without limitation, any Eligible Person or Plan Sponsor), and no such party shall have any right or cause of action hereunder.

9.3 Lawful Interpretation. Whenever possible, each provision of this Agreement will be interpreted so as to be effective and valid under applicable Law, but if any provision of this Agreement should be rendered unenforceable or invalid under applicable Law, that provision will be ineffective to the extent of such unenforceability or invalidity without invalidating the remaining provisions of this Agreement. Any such determination shall not invalidate or render unenforceable the remaining provisions of the Agreement in any other jurisdiction or under any other circumstances.

9.4 Jurisdiction. Unless otherwise specifically provided herein or mandated by applicable Law, this Agreement will be construed, governed and enforced in accordance with the laws of the State of Arizona without regard to its choice of law provisions.

9.5 Arbitration. Any and all controversies in connection with or arising out of this Agreement will be exclusively settled by arbitration before a single arbitrator in accordance with the Rules of the American Arbitration Association. The arbitrator must follow the rule of law, and may only award remedies provided in this Agreement. The award of the arbitrator will be final and binding on the parties, and judgment upon such award may be entered in any court having jurisdiction thereof. Arbitration under this provision will be conducted in Scottsdale, Arizona, and Provider hereby agrees to such jurisdiction, unless otherwise agreed to by the parties in writing or mandated by Law, and the expenses of the arbitration, including attorneys' fees, will be paid for by the party against whom the award of the arbitrator is rendered. This Section 9.5 and the parties' rights hereunder shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1 et seq.

9.6 Waiver. Failure to exercise any of the rights granted under this Agreement for any one default will not be a waiver of the right to exercise any of these rights for subsequent defaults.

9.7 Entire Agreement. This Agreement, its schedules, and the PCS Manual, On-Line Info, RECAP System Instructions and terminal, contain the entire agreement between Provider and PCS relating to the rights and the obligations of all parties concerning the provision of Pharmacy Services hereunder. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of the foregoing documents, not expressly set forth herein or therein, are terminated and of no force and effect.

9.8 Conflict Between Agreement, PCS Manual or On-Line Info. Except in the case of a provision that expressly states that it is to supersede a conflicting provision in a PCS Document, (i) if there is a conflict between any of the PCS Documents and this Agreement, the terms of the Agreement shall govern; and (ii) if there is a conflict between the PCS Manual and On-Line Info, the terms of the PCS Manual shall govern.

9.9 Headings. The heading of articles and sections contained in this agreement are for convenience only, and do not affect in any way the meaning or interpretations of this Agreement.

Schedule of Terms

AWP or Average Wholesale Price means the current wholesale cost of a given drug as defined in the latest edition of the First DataBank Blue Book (with supplements) or any other similar nationally recognized reference which PCS may reasonably select from time to time.

Copay means the amount an Eligible Person must pay to Provider at the time a Covered Item is dispensed as indicated by the RECAP® System.

Covered Item means any drug or device covered, in whole or in part, in accordance with and subject to the terms of a Plan covering an Eligible Person.

DAW Code means the NCPDP product selection codes for transmitting drug claims.

Eligible Person means a person entitled to a Covered Item pursuant to a Plan.

Law means any federal, state, local or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, order, specified standards or objective criteria contained in or which are (by express reference or necessary implication) a condition of granting any applicable permit, license, or approval required of PCS, Provider, or a Plan Sponsor, or other legislative or administrative action of the United States of America, or any state or any agency, department, authority, political subdivision or other instrumentality thereof or a decree or judgment or order of a court.

MAC or Maximum Allowable Cost means the maximum allowable cost of a drug pursuant to a Plan's list that establishes an upper limit reimbursement price for certain multiple-source drugs dispensed under the Plan without regard to the specific manufacturer whose drug is dispensed.

National Directory means a listing of the providers that have entered into an agreement with PCS substantially similar to this Agreement that are located in the United States and Puerto Rico, listing the names, addresses and certain services provided by such other providers.

NCPDP means the National Council of Prescription Drug Programs.

Networks means the PCS National Networks, the Plan Sponsor Networks, and the RECAP® Network.

On-Line Info means PCS' booklet entitled "On-Line Info," which is published and distributed semiannually to Provider, that contains information regarding certain PCS and RECAP® policies and procedures.

PCS Documents means this Agreement, including schedules, the PCS Manual, On-Line Info and information transmitted by PCS to Provider through the RECAP® System.

PCS Manual means the manual containing claims processing and program guidelines provided by PCS to Provider, as amended from time to time at PCS' sole discretion.

PCS National Networks means a network of providers that have contracted with PCS to provide Pharmacy Services to Eligible Persons, which Pharmacy Services are reimbursed by the Plan Sponsor as provided for in Section 4.3.1. The PCS National Networks presently include the Client Based Network, the Managed Care Program Network, the Performance Based Network 10 and the Performance Based Network 13.

Pharmacy Services means all services usually and customarily rendered by a provider licensed to provide pharmacy services in the normal course of business, including services mandated by applicable Law.

Plan means that portion of Plan Sponsor's drug benefit plan that relates to Covered Items with respect to a group of Eligible Persons.

Plan Sponsor means the entity that contracts with PCS for prescription benefit management services, which entity could be, among other things, an insurance company, self-insured group, health maintenance organization, preferred provider organization, multi-employer trust or third party administrator.

Plan Sponsor AWP Discount shall have the meaning used in Section 4.3.2.

Plan Sponsor Dispensing Fee shall have the meaning used in Section 4.3.2.

Plan Sponsor Network shall have the meaning used in Section 4.1

Prescriber means a person who is licensed to prescribe drugs in accordance with applicable Law.

Prior Agreements shall have the meaning used in Section 4.1.

QUANTUM Alert® means PCS' automated, nondiscretionary drug utilization review system designed to provide to the Provider at the time of dispensing, certain information in the RECAP® System that may help manage the costs of prescription drug programs and improve the quality of drug therapy provided to patients.

RECAP® Network means a network of providers that have contracted with PCS to provide Pharmacy Services to Eligible Persons of certain Plans, which Pharmacy Services are reimbursed by the Plan Sponsor as provided for in Section 4.3.3.

RECAP® System means PCS' proprietary remote electronic claim adjudication process system that provides Provider with, among other things, eligibility and drug pricing information.

Usual and Customary Price means the lowest price the Provider would charge to a particular customer if such customer were paying cash for an identical prescription on that particular day. This price must include any applicable discounts offered to attract customers.

Schedule of Provisions Applicable to Certain Providers

If Provider is located in or providing Pharmacy Services to Eligible Persons in any of the following states, the provisions set forth below with respect to that state are a part of the Provider Agreement and shall be binding on Provider. Such provisions shall be interpreted in accordance and consistent with, and in a manner that is not broader than that required by, applicable Law. Provider agrees that it will be bound by any amendments to such provisions that may be required by applicable Law and any additional provisions which are required by applicable Law that are not set forth herein.

California (Knox-Keene Health Care Service Plan Act)

1. Provider agrees to maintain reasonable hours of operation to ensure that Eligible Persons have access to Pharmacy Services at all reasonable times. Provider shall monitor waiting times and access and provide PCS, upon request, with information regarding Eligible Person's access to services.

2. Provider agrees to comply with the requirements of the Knox-Keene Health Care Service Plan Act (and the Medi-Cal program) and all other applicable laws and regulations to the extent they bear, directly or indirectly, upon the subject matter of the PCS Documents and/or operation of Provider's business.

3. Upon the request of PCS, a health care service plan contracting with PCS, the Department of Corporations, the California Department of Health Services, the United States Department of Health and Human Services and any other applicable governmental agencies, Provider shall provide access at all reasonable times to its books and records relating to the PCS Documents and to records demonstrating the financial solvency of Provider. These requirements shall survive the termination of this Agreement.

4. Provider shall cooperate with PCS' or a given Plan Sponsor's quality management and drug utilization management programs in effect from time to time. PCS shall be promptly notified of any unresolved dispute with an Eligible Person.

Kansas (Kansas Statutes Section 40-3209(b))

If Provider provides Pharmacy Services to Eligible Persons whose Plan Sponsor is a health maintenance organization ("HMO") pursuant to a provider contract between the Provider and the HMO or the PCS Documents, Eligible Persons shall not be required to guarantee payment, other than Copays and deductibles, to such Provider in the event of nonpayment by the HMO for any Pharmacy Services which have been performed under contracts between such Eligible Persons and the HMO. Further, if the HMO fails to pay for Covered Items as set forth in the contract between the HMO and the Eligible Person, the Eligible Person or covered dependents shall not be liable to any Provider for any amounts owed by the HMO. If there is no written contract between the HMO and the Provider, Eligible Persons and any covered dependents shall not be liable to the Provider for any amounts owed by the HMO.

Maine (Maine Insurance Statutes - 24-A M.R.S.A. §4204; Medicare HMO/CMP Regional Bulletin No. 64-6)

Notwithstanding any provisions in this Agreement to the contrary, Provider agrees that: (1) it will not terminate this Agreement for any reason without providing at least 60 days prior written notice to PCS; (2) in the event of an HMO's insolvency or other cessation of operations, pharmacy services to the HMO's eligible persons provided by the Provider will continue through the period for which the eligible persons' premiums have been paid to HMO, such period will not exceed 60 days in any circumstance; (3) in the event of PCS' insolvency or other cessation of operations, pharmacy services to the HMO's eligible persons provided by Provider, will be assigned to HMO and Provider agrees not to contest such assignment; (4) this Agreement will be construed, governed and enforces in accordance with the laws of the State of Maine without regard to its choice of law provision; (5) any arbitration under this Agreement will be conducted in a location in the State of Maine; and (6) all other provisions of this Agreement remain intact and enforceable including specifically Section 5.1 which provides that if a plan sponsor fails to provide PCS with funds to pay the claims of Provider, then PCS has no liability to Provider for non-payment, or for delay in payment from a plan sponsor.

Massachusetts (Medicare HMO/CMP Regional Bulletin No. 94-6)

Notwithstanding any provisions in this Agreement to the contrary, Provider agrees that: (1) in the event of an HMO's insolvency or other cessation of operations, pharmacy services to the HMO's eligible persons provided by the Provider will continue through the period for which the eligible persons' premiums have been paid to HMO, such period will not exceed 30 days in any circumstance; and (2) all other provisions of this Agreement remain intact and enforceable including specifically Section 5.1 which provides that if a plan sponsor fails to provide PCS with funds to pay the claims of Provider, then PCS has no liability to Provider for non-payment, or for delay in payment from a plan sponsor.

Missouri (Missouri Code of State Regulations Section 20 CSR 400-7.080)

1. If Provider provides Pharmacy Services to Eligible Persons whose Plan Sponsor is a health maintenance organization ("HMO") pursuant to a provider contract between itself and the HMO or the PCS Documents, under no circumstances (including, but not limited to, nonpayment by the HMO for Pharmacy Services rendered to Eligible Persons by Provider, insolvency of an HMO or an HMO's breach of any term or condition of its agreement with Provider, if any, or the PCS Documents), shall it bill, charge, collect a deposit, seek compensation, remuneration or reimbursement from or have any recourse against an Eligible Person or person acting on behalf of an Eligible Person for fees, charges or expenses relating to Pharmacy Services which the HMO is obligated to provide and pay for under the terms of the Eligible Person's subscriber agreement with the HMO.

2. The foregoing section (1) will survive the termination of the Agreement and the agreement between Provider and the HMO, if any, regardless of the cause of the termination and such section (1) shall be applicable to, and binding on, all individuals and entities with whom Provider may subcontract to provide Pharmacy Services to Eligible Persons. Nothing in this provision, however, shall in any way affect or limit Provider's right or obligation to collect from Eligible Persons copayments, deductibles or fees assessed for noncovered services in accordance with the agreement governing the Eligible Person's enrollment with the HMO.

New Hampshire (Medicare HMO/CMP Regional Bulletin No. 94-6)

Notwithstanding any provisions in this Agreement to the contrary, Provider agrees that: (1) in the event of any HMO's insolvency or other cessation of operations, pharmacy services to the HMO's eligible persons provided by the Provider will continue through the period for which the eligible persons' premiums have been paid to HMO, such period will not exceed 30 days in any circumstance; and (2) all other provisions of this Agreement remain intact and enforceable including specifically Section 5.1 which provides that if a plan sponsor fails that if a plan sponsor fails to provide PCS with funds to pay the claims of Provider, then PCS has no liability to Provider for non-payment, or for delay in payment from a plan sponsor.

Nevada (Nevada Administrative Code Section 695C.190)

Provider shall (I) release the Eligible Person from liability for the cost of Pharmacy Services rendered pursuant to a Plan Sponsor's health care plan except for any nominal payment made by the Eligible Person or for a Pharmacy Service not covered under the evidence of coverage, (ii) participate in such programs required by Nevada Law to assure the quality of Pharmacy Services provided to Eligible Persons by the Plan Sponsor through its providers, (iii) provide all medically necessary services, if any, required by the evidence of coverage and the agreement to each Eligible Person for the period for which a premium has been paid to the Plan Sponsor, (iv) give evidence of a contract of insurance against loss resulting from injuries resulting to third persons from the practice of the pharmacy profession or a reasonable substitute for it as determined by the Plan Sponsor, (v) if required by a Plan Sponsor, indemnify the Plan Sponsor for any liability resulting from the Pharmacy Services rendered by Provider and (vi) for Providers that are physicians, to transfer or otherwise arrange for the maintenance of the records of Eligible Persons who are his or her patients if Provider leaves the panel of physicians associated with the Plan Sponsor.

Rhode Island (Medicare HMO/CMP Regional Bulletin No. 94-6)

Notwithstanding any provisions in this Agreement to the contrary, Provider agrees that: (1) in the event of any HMO's insolvency or other cessation of operations, pharmacy services to the HMO's eligible persons provided by Provider will continue through the period for which the eligible persons' premiums have been paid to HMO, such period will not exceed 30 days in any circumstance; and (2) all other provisions of this Agreement remain intact and enforceable including specifically Section 5.1 which provides that if a plan sponsor fails to provide PCS with funds to pay the claims of Provider, then PCS has no liability to

Provider for non-payment, or for delay in payment from a plan sponsor.

Virginia

(14 Virginia Administrative Code Section 5-210-60 - Eligible Person Hold-Harmless)

Provider hereby agrees that in no event, including, but not limited to nonpayment by PCS' Plan Sponsors who are Virginia health maintenance organizations ("VA HMO Plan Sponsors") or PCS, insolvency of VA HMO Plan Sponsors or PCS or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Eligible Persons other than the VA HMO Plan Sponsor for Pharmacy Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of the VA HMO Plan Sponsor's subscriber agreement.

Provider further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the VA HMO Plan Sponsor's Eligible Persons and that (2) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and any Eligible Person or persons acting on such Eligible Person's behalf.

Any modifications, additions or deletions to the provisions of this hold harmless clause shall become effective on a date no earlier than fifteen (15) days after the Virginia State Corporation Commission has received written notice of such proposed changes.

(14 Virginia Administrative Code Section 5-210-80c1 - Nondiscrimination)

Provider hereby represents and warrants that Provider, or any employee or agent of Provider, shall not discriminate against any Eligible Persons enrolled with a VA HMO Plan Sponsor, on the basis of race, color, creed, national origin, ancestry, sex, age, religion, marital status, health status, lawful occupation or frequency of utilization of services.

(Section 38.2-4311 of the Code Of Virginia, Insurance - Termination Of Provider)

Notwithstanding anything to the contrary contained in the Agreement, with regard to participation in a Network in which a VA HMO Plan Sponsor participates, or in a Plan offered by a VA HMO Plan Sponsor, Provider shall give PCS at least sixty (60) days prior written notice of termination of Provider's participation in such Network or Plan.

(Provisions required pursuant to terms of Virginia Medicaid contracts)

To the extent that Provider shall provide Pharmacy Services to Eligible Persons enrolled with a VA HMO Plan Sponsor participating in the Virginia Medicaid Program, Provider shall agree to comply with any requirements for participation as a provider in the Virginia Medicaid Program.

Provider shall provide access at all reasonable times upon request by PCS or any third party identified by PCS, including any VA HMO Plan Sponsor or any state or federal agencies or departments and/or their duly authorized representatives, to inspect facilities, equipment, books, documents, papers and records relating to the performance of Provider under this Agreement, including, but not limited to, patient records, financial records pertaining to the cost of operations, and income received for the Pharmacy Services, for the purpose of making audits, examinations, excerpts and transcriptions.

Washington **(Washington Administrative Code 284-46-575)**

284-46-575. Participating provider contracts.

1. Provider hereby agrees that in no event, including, but not limited to nonpayment by a Plan Sponsor or Plan Sponsor's insolvency or breach of the PCS Documents (if applicable) shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Eligible Persons of such Plan Sponsor, other than such Plan Sponsor, acting on their behalf, for Pharmacy Services provided pursuant to the PCS Documents. This provision shall not prohibit collection of deductibles, copayments, co-insurance, and/or payments for noncovered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits or from Eligible Persons in accordance with the terms of the Eligible Person's subscriber agreement with such Plan Sponsor.

2. Provider agrees, in the event of a Plan Sponsor's insolvency, to continue to provide the Pharmacy Services

promised in this Agreement to Eligible Persons of the insolvent Plan Sponsor for the duration of the period for which premiums on behalf of the Eligible Persons were paid to Plan Sponsor or until an Eligible Person's discharge from inpatient facilities, whichever time is greater.

3. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Eligible Person's subscriber agreement.

4. Provider may not bill the Eligible Person for Covered Services (except for deductibles, copayments or co-insurance) where Plan Sponsor denies payments to PCS because Provider has failed to comply with the terms of the Agreement.

5. Provider further agrees that the above sections (1) - (4) shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the affected Plan Sponsor's Eligible Persons and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Eligible Persons or persons acting on their behalf.

6. If Provider contracts with other health care providers who agree to provide Pharmacy Services to Eligible Persons of a given Plan Sponsor with the expectation of receiving payments directly or indirectly from such Plan Sponsor, such providers must agree to abide by the above sections (1) through (5).

Applicable to Providers Where the Provider is Providing Pharmacy Services to Eligible Persons Participating in a Medicare+Choice program

To the extent that Provider shall provide Pharmacy Services to Eligible Persons who are beneficiaries of Medicare+Choice, Provider agrees to comply with any requirements for participation as a provider in a Medicare+Choice program, including, but not limited to, the following requirements set forth below. Provider agrees that it will be bound by any amendments to such provisions that may be required by applicable Law and any additional provisions which are required by applicable Law that are not set forth herein.

1. Provider acknowledges certain Plan Sponsors are a Medicare+Choice Organization that receives federal funds from the Health Care Financing Administration ("HCFA"), and that PCS is a first-tier contracting entity with such Plan Sponsors for purposes of administration of Medicare+Choice benefits. Such Plan Sponsors oversee and are accountable to HCFA for services provided to Medicare+Choice Members ("M+C Members"). Provider and its subcontractors, if applicable, agree to allow the Department of Health and Human Services ("HHS"), the Comptroller General, or their designees to inspect, evaluate and audit only pertinent contracts, books, documents, papers, and records involving transactions related to services provided to Plan Sponsor's M+C Members. This right to inspect, evaluate and audit shall exist for a period of six (6) years from the final date of the contract period or from the date of completion of any audit, whichever is later. Further, Provider acknowledges that its performance of services to M+C Members under this Provider Agreement will be monitored by the Plan Sponsor on an ongoing basis.

2. Provider agrees to safeguard the privacy of any information that identifies a particular patient. Information of this nature may be released only to authorized individuals and both parties agree to ensure that unauthorized individuals cannot gain access to or alter patient records. Further, the parties agree to maintain records in an accurate and timely manner, and to ensure timely access by patients to records and information that pertains to them, abide by all applicable state and federal laws regarding confidentiality and disclosure of patient records and information, and release original medical records only in accordance with federal or state laws, or court order.

3. Provider agrees that all services provided pursuant to this Provider Agreement will be rendered in a manner consistent with professionally recognized standards of health care, and in a culturally competent manner.

4. Provider agrees to accept the compensation set forth in the Provider Agreement as full compensation for providing services to a M+C Member without recourse to any M+C Member for any amount except such Copays, coinsurance, or deductible amounts as may be applicable. Provider shall look only to Plan Sponsor for compensation for services provided to a M+C Member, except for applicable Copays, coinsurance or deductible amounts. Provider agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge from, or have any recourse against any M+C Member, or person acting on behalf of a M+C Member (except for Plan Sponsor), except to the extent Copays, deductibles, or coinsurance are applicable. Provider agrees not to maintain any action at law or in equity against any M+C Member to collect sums owed by Plan Sponsor under the terms of this Provider Agreement, even in the event that Plan Sponsor fails to pay, becomes insolvent, or otherwise breaches the terms of its agreement with PCS. This Article shall survive termination of this Provider Agreement, regardless of the cause of the termination, and shall be construed to be for the benefit of M+C Members. This Article is not intended to apply: (i) to services provided after termination of this Provider Agreement, except as otherwise provided in the Provider Agreement, or (ii) to non-covered services. Provider further agrees that this provision supercedes any oral or written agreement hereinafter entered into between the Plan Sponsor and M+C Member or other person acting on M+C Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of the Provider Agreement.

5. Provider agrees that delegation of any activities or responsibilities of Provider under the Provider Agreement shall be governed by an addendum which will be made a part of the Provider Agreement. Any delegated service will be performed in a manner consistent and in compliance with Plan Sponsor's obligations to HCFA.

6. Provider, and any subcontractor of Provider, if any, agree to certify as to the accuracy, completeness and truthfulness of data submitted to PCS.

7. Provider agrees to comply with all applicable state and federal laws, including but not limited to Title VI of

the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans With Disabilities Act, and all other laws applicable to recipients of federal funds, from which payment to Provider are made in whole or in part. Provider further agrees to comply with all applicable Medicare laws, regulations and HCFA instructions.

8. Provider, and subcontractor of Provider, if any, agree to cooperate with an independent quality review and improvement organization's activities pertaining to provision of services for M+C Members in Plan Sponsor's plan.

9. Provider agrees to refrain from employing or contracting with any individual or any entity that employs or contracts with an individual who is excluded from participation in Medicare and/or Medicaid under Sections 1128 and 1128A of the Social Security Act for the provision of: (a) health care; (b) utilization review; (c) medical social work; and (d) administrative services.

Applicable to Providers Where the Provider is Providing Pharmacy Services to Eligible Persons Participating in a Plan Sponsor that is a Health Maintenance Organization Providing Supplemental Prescription Benefits Pursuant to Medicare ("HMO Medicare Plan Sponsor")

To the extent that Provider shall provide Pharmacy Services to Eligible Persons participating in a Plan Sponsor that is a HMO Medicare Plan Sponsor, Provider agrees to comply with any requirements for participation as a provider of a HMO Medicare Plan Sponsor, including, but not limited to, the following requirements set forth below. Provider agrees that it will be bound by any amendments to such provisions that may be required by applicable Law and any additional provisions which are required by applicable Law that are not set forth herein.

Grievance Procedures and Quality Assurance Programs: Provider shall (i) comply with any grievance, appeal and dispute resolution procedure and (ii) participate in any quality assurance program, implemented by PCS or an HMO Medicare Plan Sponsor to comply with guidelines promulgated by the Health Care Finance Administration ("HCFA") that are applicable to an HMO Medicare Plan Sponsor.

Continuation of Coverage: Provider agrees that in the event of an HMO Medicare Plan Sponsor's insolvency or other cessation of operations, Provider shall continue to provide Pharmacy Services to the applicable HMO Medicare Plan Sponsor's Eligible Persons through the period for which the HMO Medicare Plan Sponsor has received the premium for such Pharmacy Services.

Prior Approval: Provider acknowledges that an HMO Medicare Plan Sponsor shall have the opportunity to grant prior approval or disapprove of any provider that will provide Pharmacy Services to its Eligible Persons.

Nondiscrimination: Provider hereby represents and warrants that Provider, or any employee or agent of Provider, shall not discriminate against any Eligible Persons enrolled with an HMO Medicare Plan Sponsor on the basis of race, religion, sex, color, national origin, age, health status, handicap, source of payment or on the basis of the Eligible Person's membership in the HMO Medicare Plan Sponsor.

Access to Documents and Facilities: Provider shall maintain pharmacy records related to Eligible Members enrolled with a HMO Medicare Plan Sponsor and provide access to such records and its facilities at all reasonable times upon request by PCS or any third party identified by PCS, including any HMO Medicare Plan Sponsor or any state or federal agencies or departments and/or their duly authorized representatives.

Utilization Management, Licensure, Insurance and Credentialing: Provider shall (i) participate in and cooperate with the decisions, rules and regulations established by any utilization management program implemented by a HMO Medicare Plan Sponsor to comply with HCFA guidelines, (ii) notify PCS immediately in the event of any change in the Provider's licensure and in such notice direct PCS to so notify all of its HMO Medicare Plan Sponsors, (iii) maintain adequate liability and malpractice coverage through insurance, self-funding or other means satisfactory to an HMO Medicare Plan Sponsor and to notify PCS within ten (10) days prior to any reduction or cancellation of such coverage and in such notice to direct PCS to so notify all of its HMO Medicare Plan Sponsors and (iv) cooperate in a HMO Medicare Plan Sponsor's credentialing processes.

Other Requirements Applicable to Medicare Contracts: To the extent that Provider shall provide Pharmacy Services to Eligible Persons enrolled with a HMO Medicare Plan Sponsor, Provider shall agree to comply with any additional requirements for participation as a provider in the Medicare Program.

Schedule of Transmission and Maintenance Fees

PCS offers Provider three ways to telecommunicate claims: direct dial, a Provider-supplied line (*i.e.*, a leased line that is provided by and paid for by Provider) or through the PCS RECAP® Terminal. The transmission fee charged for each claim verified as a Covered Item (whether submitted on-line via the RECAP® System, on paper, tape or electronically in a batch format) is as follows:

	Provider Supplied Line	PCS Communication Network
Provider using its own computer system	$.03	$.12
Provider using leased RECAP® Terminal:		
Option One	N/A	$.20 ($4.50 minimum transmission charge per cycle)
Option Two*	N/A	$.12 ($10.00 maintenance fee per cycle)
Provider using purchased RECAP® Terminal:		
	N/A	$.12 ($5.00 maintenance fee per cycle or $100 per occurrence if no cycle fee is deducted)

* Not available for new Providers

PCS Health Systems, Inc.
Network and Plan Enrollment Form

The undersigned hereby enrolls as a Provider in one or more of PCS' Networks. The attached Provider Agreement, all Schedule thereto, and the PCS documents (as defined in the Provider Agreement) each as in force from time to time constitute Provider's agreement with PCS Health Systems, Inc.

IN WITNESS WHEROF, the parties hereto have caused this Provider Agreement to be executed by their respective officers or representatives duly authorized so to do effective as of the date PCS Health Systems, Inc. accepts this Provider Agreement. By signing below, the undersigned Provider represents and warrants to PCS Health Systems, Inc. that (i) it has read the PCS Provider Agreement, the Schedules thereto and the other PCS documents, and (ii) agrees to be bound by such agreements (as such agreements may be amended from time to time in accordance with the terms of the Provider Agreement) without any modifications, deletions or additions to any of such agreements.

Provider

Name: Walgreen Co.

Address: 200 Wilmot Rd., Deerfield, IL 60015

NCPDP: previously supplied

Telephone: 847/914-2663

Fax: 847/914-3109

By: Denis R. O'Dell

PCS Health Systems, Inc.

By: John M Davis

John M. Davis
Printed Name and Title

Date of Acceptance by PCS: 11/8/01

Please indicate contact name, address and telephone number:

Frank Mangham (847)914-2663
~~Joseph Noll (847) 753-~~6866
Contact Name

200 Wilmot Rd.,
Address

Deerfield, IL 60015
City State Zip Code

see above
Telephone

Exhibit 2

IMPORTANT NOTICE TO PHARMACY PROVIDERS

Effective March 24, 2004, the planned acquisition of AdvancePCS by Caremark Rx was completed. Accordingly, AdvancePCS (now CaremarkPCS), and Caremark Inc., are both wholly owned subsidiaries of Caremark Rx.

Prior to this acquisition, your pharmacy may have had a contract with AdvancePCS and/or Caremark Inc. To facilitate the integration process, both companies will be using the same base pharmacy provider agreement effective August 1, 2004. The new agreement will consist of the AdvancePCS Provider Agreement, along with Exhibit B to the Caremark Participating Pharmacy Agreement, all Attachments to this Exhibit B, and any fee schedules which you have previously entered into with Caremark Inc. This new agreement will apply to all of your CaremarkPCS and Caremark Inc. business beginning August 1, 2004 and will be called the "Caremark Provider Agreement." Except for the portions noted above, the old Caremark Participating Pharmacy Agreement will not apply to your Caremark Inc. business after August 1, 2004. Communications from Caremark may reflect the name of either AdvancePCS or Caremark until the integration process is complete.

We are pleased to announce that both CaremarkPCS and Caremark Inc. will pay pharmacies for prescriptions dispensed in accordance with the Provider Agreement, regardless of whether payment is received from our customers. Caremark will no longer require pharmacies to accept our organization as a limited agent for payment purposes. Accordingly, you may consider Section 5.1 of the Provider Agreement deleted.

During the integration process, your pharmacy should continue to submit and process claims according to the following table:

Caremark Processing Centers

Card Graphic / Previous Claim Processor	Processing Center as of 03/24/04	BIN #
Caremark Inc.	Caremark Facility	610029
AdvancePCS - RxClaim	Caremark - RxClaim Facility	004336
AdvancePCS - RECAP	Caremark - RECAP Facility	610415

You will be notified of which BIN to submit claims to for new plan sponsors.

In addition, during the integration process, the pharmacy payment cycles and pharmacy payment schedules will continue as previously in place for Caremark and AdvancePCS. For claims submitted to BIN 004336 and 610415, your pharmacy payment cycles and payment schedule will remain the same as AdvancePCS had in place prior to the acquisition. Similarly, for claims submitted to BIN 610029, your pharmacy payment cycles and payment schedule will remain the same as Caremark had in place prior to the acquisition. As a result, you will be receiving from Caremark reimbursement for claims through separate checks according to different schedules based on the BIN to which the claims were submitted.

We look forward to the opportunity to enhance our relationship with your pharmacy.

Thank you,
Retail Services

Exhibit 3

CAREMARK

May 31, 2007

IMPORTANT INTEGRATION NOTICE REGARDING CAREMARK AND PHARMACARE

Effective March 22, 2007, the merger of Caremark Rx, Inc. and CVS Corporation was completed. As part of that merger, the prescription benefit management operations of PharmaCare Management Services, Inc., which also includes ClaimsPro Health Claims Services, Inc., TDI Managed Care, Inc. (d/b/a Eckerd Health Services – EHS), and United Provider Services, (collectively, PharmaCare), have merged with Caremark.

Prior to this merger, Walgreens had a provider contract with PharmaCare and Caremark. However, to facilitate the integration process, we will now be using your existing Caremark Provider Agreement (f/k/a the PCS Health Systems, Inc. Provider Agreement), including the Caremark Medicare Part D addendums, for all Caremark and PharmaCare business. Accordingly, for your PharmaCare business, the provider agreement will consist of your Caremark Provider Agreement (f/k/a the PCS Health Systems, Inc. Provider Agreement), the Caremark Pharmacy Manual (f/k/a AdvancePCS Provider Manual), and the PharmaCare fee schedules listed below as these fee schedules will be incorporated into the Caremark Provider Agreement, all effective September 1, 2007. Except for the specific fee schedules listed below, the collective PharmaCare provider agreements will not apply after September 1, 2007.

Advantage Health Solutions
Community Health Plan
Fallon Community Health Plan (commercial and Medicare Part D networks)
Great Northern Network
HealthPartners (Medicare Part D networks)
Massachusetts Managed Care Addendum
Massachusetts Preferred Pharmacy Addendum
RI Help – RI Prescription Drug Discount for the Uninsured
The State of Connecticut Employees Network

Communications from Caremark may reflect the name of PharmaCare, ClaimsPro, EHS, United Provider Services, or Caremark until the integration process is complete.

We are pleased to announce that both Caremark and PharmaCare will pay pharmacies for prescriptions dispensed in accordance with the Caremark Provider Agreement, regardless of whether payment is received from plan sponsors.

In addition, during the integration process, the pharmacy payment cycles and BINs will continue as previously established by Caremark or PharmaCare. You will be notified of which BINs to submit claims to for new plan sponsors.

Your understanding and assistance during this integration process is greatly appreciated, and we look forward to working with your pharmacy over the coming years.

Thank You,
Caremark Retail Services

CAREMARK

May 31, 2007

Dear Pharmacy Provider:

We are pleased to provide you with several important updates regarding **Caremark** and **PharmaCare**. Enclosed in this package are:

- This cover letter
- Important Integration Notice Regarding Caremark and PharmaCare
- The new Caremark Provider Manual

Caremark Provider Manual Updates
The new Caremark Provider Manual applies to your Caremark business effective July 1, 2007, and your PharmaCare business effective September 1, 2007, in accordance with the Integration Notice enclosed in this package.

In addition to addressing updates to the Medicare Part D Program and National Provider Identification number (NPI) initiative, the Provider Manual includes other changes such as:

- Re-organization of the payer sheet, transaction standards, rejection codes as appendices
- Addition of/changes to the following sections: the Federal Health Care Programs Participation Exclusion, Diverse Retail Pharmacy Program, Provider Identification Number, Compounded Medications, Provider Payment, Provider Suspension and U&C Validation

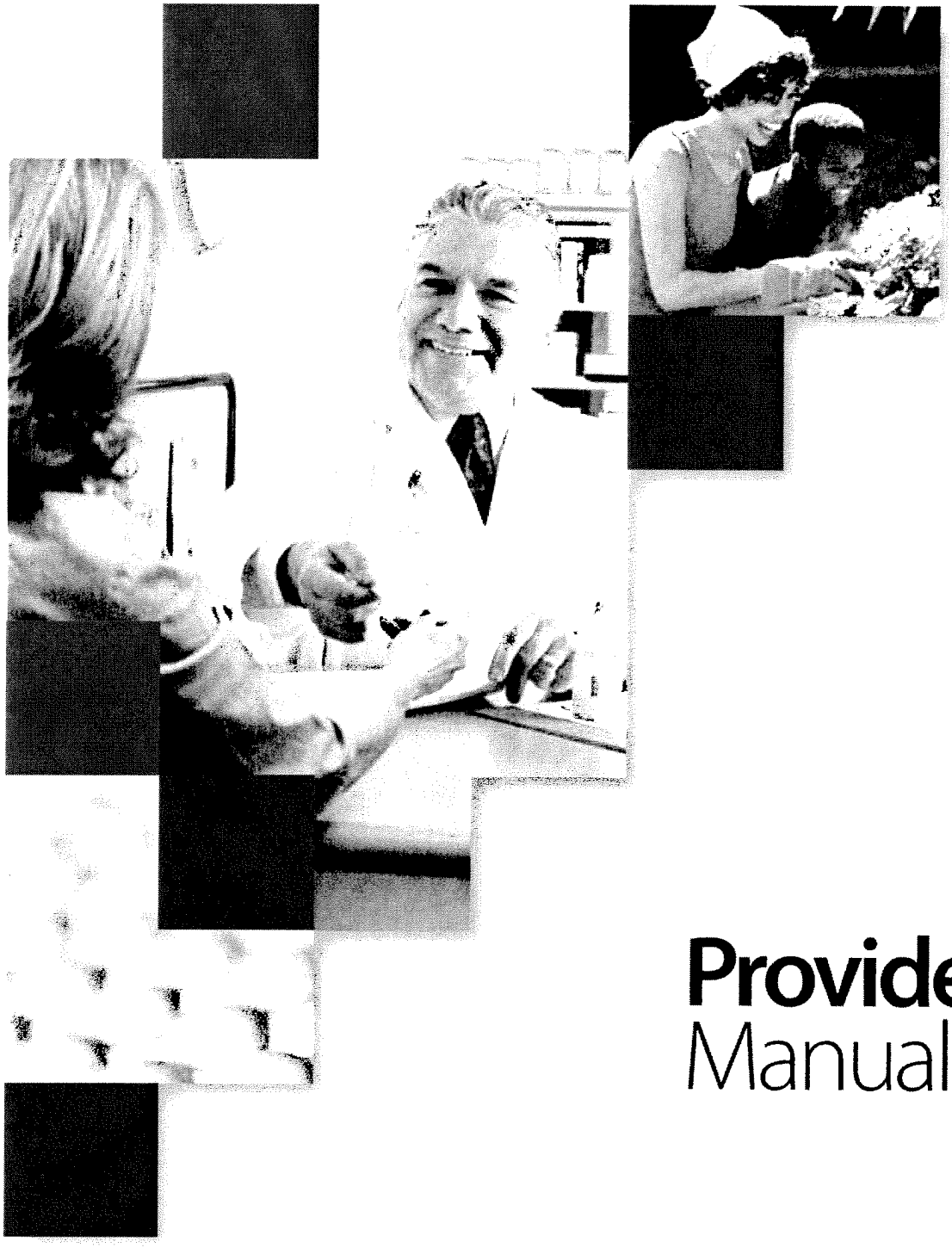
Provider Contract Updates
Please read the enclosed Integration Notice that explains which provider agreement will be used as we facilitate the integration process between Caremark and PharmaCare. We also outline various PharmaCare fee schedules that will be incorporated into the Caremark Provider Agreement.

Caremark has also recently converted Caremark Inc. and CaremarkPCS into a limited liability company structure. Accordingly, all Caremark Provider Agreements are contracted with Caremark L.L.C. and CaremarkPCS L.L.C.

Also, for providers participating in the Consumer Card Provider Network II, Caremark Managed Cash (CMC) Network, RxClusive Consumer Card Savings Network or any consumer card network where an Eligible Person may be charged an administrative fee at the point of sale, the administrative process fee will be included in the applicable field(s) of the claim Response Pricing Segment.

If you have any questions, please contact Caremark Retail Services at **1-866-488-4708**.

Thank you,
Caremark Retail Services



Provider Manual

CAREMARK®
It all starts with care®

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General Information

This Caremark Provider Manual ("Provider Manual") supersedes all previous versions of OnLine Infos, PCS policies, and PCS, AdvancePCS, Caremark, and PharmaCare (which includes ClaimsPro, United Provider Services, and Eckerd Health Services) provider manuals.

Capitalized terms used in the Provider Manual not defined in the Glossary of Terms shall have the same meaning as in the Provider Agreement.

Proprietary Statement

The information contained in this Provider Manual is confidential and proprietary to Caremark and provided for business purposes only. Provider cannot copy, reproduce, distribute or otherwise share the information contained in this Provider Manual except as authorized by the Provider Agreement. The Caremark Provider Manual must be surrendered to Caremark upon termination as a Provider for whatever reason.

Document Adherence

The Caremark Provider Manual is a part of the Caremark Documents and incorporated into the Provider Agreement with Caremark. Provider must abide by the provisions and terms set forth in the Provider Agreement. Nonadherence to any of the provisions and terms of the Provider Agreement (which includes the Provider Manual and all other Caremark Documents) will be a breach of the Provider Agreement with Caremark.

Help Desk

Inquiries for which the Caremark Provider Manual or the claim system response does not address can be directed to the interactive voice response (IVR) system or the Caremark Help Desk. The IVR is available 24 hours a day, 7 days a week, excluding downtime for maintenance and service. The Caremark Help Desk is open every day of the year except Independence Day, Thanksgiving Day and Christmas Day, and is staffed with representatives. Following are the phone numbers corresponding with the appropriate Bank Identification Numbers (BINs):

BIN	PHONE NUMBER
610415*	**1-800-345-5413**
004336*	**1-800-364-6331**
610029*	**1-800-421-2342**
610468	**1-800-777-1023 or 1-800-503-3241**
006144	**1-800-777-1023 or 1-800-503-3241**
004245	**1-800-837-9600**
610449	**1-800-519-8374**
603604	**1-800-785-5301**
610474	**1-800-785-5301**

*Help Desk phone number serving Puerto Rico Providers is available by calling toll-free **1-800-842-7331**.

Help Desk representatives will use reasonable efforts to assist Providers. A licensed pharmacist also will be available to answer questions. However, the pharmacist will not be able to provide any professional advice with respect to the provision of Pharmacy Services.

Contact Information

Providers must send inquiries, grievances and requested changes in writing about the information communicated in the Caremark Provider Manual and/or Caremark Documents, or other questions in general to:

Caremark
Attn: Network Management, MC 080
9501 East Shea Boulevard
Scottsdale, Arizona 85260

Top Questions Asked by Providers

1. **What date of birth, sex and/or person code do you have on file for this Eligible Person?**
   In the event a member's eligibility information is incorrect, when a Provider submits a claim using the correct eligibility information, it will reject. In most cases, Caremark will be able to assist the Provider at the point-of-service with any discrepancies with eligibility information, such as date of birth and sex. However, you should advise your patient that he/she should inform his/her Plan Sponsor of the incorrect eligibility information and that until it is corrected, claims will continue to reject.
2. **What is the identification number for this Eligible Person?**
   Provider must request to see the identification card for the Eligible Person to ensure that the prescription is written by the Prescriber for an Eligible Person. The Help Desk can not conduct an ALPHA search utilizing the name of the Eligible Person.
3. **What is the RXGRP number for this Eligible Person?**
   Provider must request to see the identification card for the Eligible Person to ensure that he/she is submitting the claim to the correct prescription benefit management organization under the correct Plan Sponsor. Provider must examine both sides of the card to ascertain the RXGRP number and other data requirements.
4. **Is a processor control number (RXPCN) required for claim submission?**
   Provider must request to see the identification card for the Eligible Person and examine the card to determine if RXPCN information is available. Submit the RXPCN information as it appears on the identification card. If no RXPCN appears on the identification card, submit the default RXPCN according to the banking identification number (RXBIN) as directed by the appropriate Help Desk (as indicated from the chart on page 2 of this Provider Manual).
5. **What is the amount this patient must pay?**
   Provider must submit the claim through the claims system to receive the adjudicated response, which will include the amount to collect from the Eligible Person as well as information about eligibility, Plan coverage, pricing and applicable clinical programs and services. The representatives at the Help Desks cannot release information about the amount the Eligible Person must pay due to the variables that may impact cost share.
6. **Is this Eligible Person eligible to receive a vacation supply?**
   Many Plan Sponsors allow for Eligible Persons to secure an early refill for vacation supply. If the Eligible Person states that he/she is eligible for an early refill for vacation supply, Provider must submit the claim as usual. If the claim rejects, Provider should contact the appropriate Help Desk for coverage verification. If the Plan Sponsor does allow for an early refill for vacation supply, the representative from the Help Desk will provide a prior authorization code.
7. **What is the prior authorization procedure for this Eligible Person?**
   Caremark only administers prior authorization programs for some of its Plan Sponsors. Therefore, Provider should note the adjudication response, which generally includes the on-line retransmission instruction or appropriate contact information and telephone numbers.
8. **What are the plan limits for this Eligible Person?**
   Provider must submit the claim through the claims system to receive the adjudicated response, which will include messaging about plan coverage. The representatives at the Help Desks cannot release plan limitation information due to the variables that may impact the coverage for a given drug.
9. **What data field do I use for the <specific data>?**
   Representatives from the Help Desks will reasonably assist Provider where possible to determine which data field should be used for specific data. However, due to the numerous types of software, it is difficult for the representatives to know how each system is set up. Providers should consult with their software vendor or chain headquarters for technical assistance.
10. **How do I bypass the interactive voice response (IVR) system to get a representative?**
    The IVR system provides easy access to necessary information. If the response from the IVR is not comprehensive, Provider can press 0 at anytime during the call to access a representative to obtain further explanation.
11. **What RXBIN do I use for all Caremark Eligible Persons?**
    Provider should submit claims utilizing the corresponding RXBIN 610415, 004336, 610029, 610468, 006144, 004245, 610449, 603604, or 610474 unless otherwise specified. In most cases, the RXBIN is illustrated on the identification card.

Credentialing and Quality Management

Provider must comply with the credentialing and quality management initiatives required by Caremark, and Provider agrees to provide Caremark with documentation and other information that may be needed in connection with such initiatives.

Caremark has the right to reasonably determine in its sole discretion whether or not Provider meets and maintains the appropriate credentialing and quality management standards to serve as a provider for Caremark and its Plan Sponsors.

Standards of Operation

Provider must meet all standards of operation as described in Federal, State and local Law. Shipping Covered Items to Eligible Persons by mail or other remote delivery carrier as a routine business practice is unapproved without the express written permission of Caremark.

Licensure

Provider must at all times maintain in good standing with all Federal, State and local licenses and/or permits as required by applicable Law. Provider must furnish copies of said licenses and/or permits upon enrolling as a Provider with Caremark and as requested by Caremark. Failure to maintain the appropriate licenses and/or permits will result in immediate termination as a provider.

Reporting of Investigations and Disciplinary Actions

Provider must notify Caremark immediately in writing if its license(s) and/or permit(s) are, or are in jeopardy of being, suspended or revoked. Provider must also notify Caremark immediately in writing if it receives notice of any proceedings that may lead to disciplinary actions or if any disciplinary actions are taken against Provider or any of its personnel, including actions by Boards of Pharmacy, OIG, GSA, or other regulatory bodies. Failure to immediately notify Caremark in writing of any such investigations or disciplinary actions may result in immediate termination or suspension as a provider.

Caremark may immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding or claims adjudication suspension) of Provider if Caremark has reason to believe that Provider has engaged in, or is engaging in, behavior that (i) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or (ii) does not meet the quality management standards to serve as a provider for Caremark or its Plan Sponsors.

Federal Health Care Programs Participation Exclusion

Providers who are not eligible to participate in Medicare, Medicaid, and other Federal health care programs are not eligible to participate in any of the Caremark networks. If excluded from participation in Federal health care programs by the Federal government, the Provider will be immediately terminated from participation in all Caremark networks.

Provider shall not allow any employees or contractors excluded from participation in Medicare, Medicaid, or other Federal health care programs to provide services that involve furnishing, ordering or prescribing an item or service that will be paid by Medicare, Medicaid, or other Federal health care programs. Provider agrees to implement a policy requiring all new and existing employees and contractors responsible for furnishing, ordering or prescribing an item or service that will be paid by Medicare, Medicaid, or other Federal health care programs to immediately disclose to Provider any debarment, exclusion, or other event that makes them ineligible to perform work related directly or indirectly to Federal health care programs, and upon such disclosure, Provider will immediately reassign such employee or contractor to work that does not involve or relate directly or indirectly to Medicare, Medicaid, or other Federal health care programs.

Provider hereby certifies, and agrees to provide such further additional certification in this regard, as Caremark may reasonably require, that Provider: (i) will review the OIG and GSA exclusions lists upon initially hiring any employee or contractor and annually thereafter to ensure that any officer, director, employee or contractor engaged by Provider that is responsible for furnishing, ordering or prescribing an item or service that will be paid by Medicare, Medicaid, or other Federal health care programs is not excluded from Federal health care programs; and (ii) that if an employee or contractor of Provider that is responsible for furnishing, ordering or prescribing an item or service that will be paid by Medicare, Medicaid, or other Federal health care programs is on such lists, Provider will immediately remove such employee or contractor from any work related directly or indirectly to Medicare, Medicaid, or other Federal health care programs and will take appropriate corrective actions.

Insurance

Provider must at all times hold policies for general and professional liability insurance, including malpractice, in amounts necessary to ensure that Provider and any of its personnel are insured against any claim(s) for damages arising from the provision of Pharmacy Services. Such policies must have coverage, at a minimum, in the amount of $1,000,000.00 per person and $3,000,000.00 in aggregate, unless otherwise agreed to by Caremark, or such greater amount required by Law.

Provider must furnish copies of said policies upon enrolling as a Provider with Caremark and as requested by Caremark thereafter. Failure to maintain the minimum coverage may result in immediate termination as a Provider.

Provider must notify Caremark immediately in writing if its insurance is canceled, lapsed or otherwise terminated. Failure to immediately notify Caremark in writing of any such termination of insurance coverage may result in immediate termination as a Provider.

The requirements in this section apply to the extent permissible under applicable Law.

Quality Management

Provider must participate in quality management initiatives or other Plan Sponsor programs, as requested by Caremark and/or Plan Sponsors. Provider must also maintain internal quality management standards and procedures and furnish an outline of said standards and procedures as requested by Caremark.

Provider Enrollment

To enroll as a Provider to participate in a Caremark or Plan Sponsor network, Provider must dial 1-800-345-5413 and, when prompted by the voice response unit, press the option for provider enrollment (new or changing Provider information) or network enrollment (Caremark member pharmacies wishing to participate in a Plan Sponsor network). Caller must then state Provider name, the corresponding NPI and NCPDP number, the contact name, the telephone number, and the reason for the call.

Caremark will charge a minimum fee of $100 for each application of enrollment regardless of whether Caremark accepts the pharmacy as a Provider.

Changes in Documentation and Other Information

Provider must notify Caremark in writing within 10 days of any changes in the documentation and other information provided to Caremark in connection with enrolling as a Provider and in any credentialing or quality management initiatives.

Provider Information Updates

Provider must notify Caremark in writing within 10 days of any changes in the documentation and other information provided to Caremark in connection with enrolling as a Provider and in any credentialing or quality management initiatives. Such information, including but not limited to, changes in name, address, telephone number, fax number, services, and/or ownership, must be sent by either: (1) fax to 480-661-3054; or (2) mail to:

Caremark
Attn: Provider Enrollment, MC 129
9501 E. Shea Boulevard
Scottsdale, AZ 85260

Diverse Retail Pharmacy Program

The Caremark Supplier Diversity Program was established in 2000, and targets diverse suppliers of products and services for Caremark's use. The program is designed to complement Caremark's commitment to providing outstanding service to its customers, and it recognizes the critical role diverse suppliers have in its continued success. The Supplier Diversity Program is founded on the principles of sound business practices and social responsibility to the community in which Caremark serves.

One component of the Supplier Diversity Program is the Diverse Retail Pharmacy Program, initiated by Caremark in 2004. Under this program Caremark encourages diverse-owned, independent retail pharmacies to become certified business enterprises in order to expand and establish potential business opportunities, sustain and grow their business, take advantage of possible governmental programs, and expand and establish potential new opportunities with other business entities.

Any diverse owned and operated retail pharmacy contracted with Caremark and certified as a diverse business enterprise by a government or third-party entity can apply for participation in the Diverse Retail Pharmacy Program. Just complete and submit the Caremark Supplier Profile Form. For more information on this program and the Caremark Supplier Profile Form, please refer to **Appendix F** of this Provider Manual.

Pharmacy Services and Standards

Verification of Eligible Persons

Providers will be paid for claims only for the Eligible Person for whom a prescription for a Covered Item was written by the Prescriber and dispensed to the Eligible Person.

Prior to dispensing a Covered Item to an Eligible Person, Provider will inquire whether such Eligible Person has any prescription benefit coverage (including both public and private sources of coverage) in addition to such Eligible Person's benefit under a Plan. If such Eligible Person has additional prescription benefit coverage of any kind, Provider will submit its claim to the appropriate payer as required by and in accordance with any coordination of benefits requirements, and will engage in appropriate coordination of benefits activities to the extent required by Caremark, or applicable by Law.

Caremark and/or Plan Sponsors will provide Eligible Persons with identification cards. Provider must request the identification card from the Eligible Person and utilize the information on the identification card to submit claims through the claims system. If an identification card is unavailable at the point of service, reasonable attempts/efforts should be made to obtain the necessary information for claim submission. Provider will not be paid for providing Pharmacy Services related to Covered Items to an Eligible Person whose eligibility was not correctly submitted.

Identification Cards

In most cases, the identification card will be produced in the National Council for Prescription Drug Programs (NCPDP) format and will contain the Eligible Persons' identification number, the bank identification number (RXBIN) and the group (RXGRP) and/or the processor control number (RXPCN). Some Plan Sponsors produce identification cards that may or may not include this information.

An identification card may show coverage for the Eligible Person only or it may show coverage for the Eligible Person and his or her dependents.

Nondiscrimination

Provider must not discriminate against an Eligible Person on the basis of race, color, national origin, gender, religion, disability, medical condition, political convictions, sexual orientation, and marital or family status. Unless professional judgment dictates otherwise, Provider must deliver Pharmacy Services related to Covered Items to all Eligible Persons.

Collection of Patient Pay Amounts

Plan Sponsors determine the Patient Pay Amounts for which Provider must collect from an Eligible Person for the Pharmacy Services related to a Covered Item. Patient Pay Amounts vary by Plan Sponsor and/or Plan. Therefore, Provider must collect from the Eligible Person the Patient Pay Amount as indicated by the claims system unless otherwise directed by Caremark or as otherwise permitted under applicable Law.

Provider shall disclose to each Eligible Person Provider's Usual and Customary Price if such Usual and Customary Price is less than the applicable Patient Pay Amount. Provider shall allow the Eligible Person to pay either the Usual and Customary Price or the Patient Pay Amount, whichever is lower, unless a Plan otherwise requires. Notwithstanding the foregoing, Provider shall still submit a claim to Caremark, even if the Eligible Person elects to pay the Usual & Customary Price.

Providers cannot waive, discount, reduce or increase the Patient Pay Amount communicated by the claims system unless otherwise authorized in writing by Caremark or as otherwise permitted under applicable Law. In addition, if Caremark determines that Provider has charged or collected from an Eligible Person in excess of the Patient Pay Amount communicated by the claims system, Provider must promptly reimburse Eligible Person for the excess amount upon request from Caremark. Otherwise, Caremark has the right to recover said excess amounts or unauthorized fees from the Provider (including by offset against other amounts owing to Provider) and return the recovered amounts to the appropriate Eligible Person.

Limitation on Collection

Except for the Patient Pay Amount, Provider cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an Eligible Person for the provision of Pharmacy Services related to a Covered Item in any event, including nonpayment by or bankruptcy of a Plan Sponsor or Caremark.

Documentation

Provider must maintain all documents and records related to Covered Items dispensed to Eligible Persons in accordance with industry standards in a readily obtainable location for a minimum of three years or such longer period as required by Law. Such documents and records may include, but are not limited to, original prescriptions; signature logs; daily prescription logs; wholesaler, manufacturer and distributor invoices; Prescriber information; and patient profiles. See the **Professional Audit** section for more detail on documentation requirements.

Signature Log – Hard Copy or Electronic

Provider must utilize a third party signature log – hard copy or electronic – approved by Caremark. The information must include, but is not limited to, the date the product was received by the Eligible Person or participant, the prescription number, the name of the third party program, authorization for the release of the information to Caremark and/or Plan Sponsor.

For each Covered Item dispensed to an Eligible Person, Provider must obtain the signature of the Eligible Person (or his or her authorized representative) on the third party signature log to confirm that he or she has received the medication recorded and has read the NCPDP-approved patient disclaimer or mutually agreed upon acknowledgement which confirms that the patient representative has received the medication.

Performance Initiatives

Provider must support Caremark performance initiatives, such as, but not limited to, Performance Drug program, Drug-Drug Interaction Reject program, closed formulary, prior authorization, Managed Drug Limitations program, generic incentive programs, Dose Optimization program, and Prerequisite Step Therapy program (see **Clinical Programs, Services and Related Messages** section of this Provider Manual for a further description of these initiatives).

As part of the performance initiatives, Provider must inform Eligible Persons when a nonformulary drug has been prescribed and Provider must use best efforts to contact the prescribing physician to encourage formulary compliance. Provider may be paid a fee for services related to performance initiatives. See the **Performance Drug Program** section of this Provider Manual.

Educational Materials and Efforts

Providers must utilize all educational materials to benefit Eligible Persons. All information contained in educational materials related to products, programs, services, and Plan Sponsor announcements constitute part of the Caremark Documents and are confidential and proprietary to Caremark.

Caremark may educate Provider about products, programs and services as well as distribute Plan Sponsor announcements. Educational materials may be distributed through various means, including e-mail, facsimile, mail, or posted on one of the Caremark websites.

Eligible Person Complaints

Provider must cooperate with Caremark and/or Plan Sponsors to resolve complaints by Eligible Persons. Provider must make a reasonable effort to rectify the situation that leads to the complaint from an Eligible Person. Provider must maintain written records of events and actions surrounding each complaint.

If as a result of an Eligible Person complaint, audit review and/or prescriber verifications, Caremark identifies and reviews a potential dispensing error and confirms with Provider the occurrence of a dispensing error, Provider will review the information with the Eligible Person, document the incident in accordance with Provider's internal and/or corporate procedures, and report the incident to any appropriate regulatory agency. For paid claims that have been determined to have a dispensing error, Caremark reserves the right to charge back the entire claim amount.

Professional Judgment and Conduct

All Pharmacy Services must be rendered under the direct supervision of a licensed pharmacist and according to Prescriber directions or as otherwise required by applicable Law. Provider must at all times exercise professional judgment in providing Pharmacy Services to an Eligible Person. Provider may refuse to provide Pharmacy Services to an Eligible Person based on that professional judgment. The preceding notwithstanding, nonadherence to any of the provisions and terms of the Provider Agreement will be a breach of the Provider Agreement with Caremark, unless otherwise governed by applicable Law.

Claims Submission

Provider must submit all claims for Pharmacy Services related to Covered Items for Eligible Persons electronically through the applicable claims system. Provider must transmit with each claim the information requested by the Provider Agreement and the claims system. Provider must only submit claims for which Pharmacy Services were provided to an Eligible Person and for Covered Items as prescribed by a Prescriber. Submitted claims information must be accurate and complete. Each claim submitted by Provider will constitute a representation by the Provider to Caremark that the Pharmacy Services were provided to the Eligible Person and that the information transmitted is accurate and complete.

Claims submission must occur from the Dispensing Pharmacy, unless Caremark expressly authorizes otherwise.

Schedule of Claims Systems Maintenance

Maintenance of the claims systems may be scheduled between 12:01 AM and 4:00 AM Mountain Standard Time (MST) each Sunday. During the scheduled maintenance, Providers will receive the message, "HOST UNAVAILABLE." If this message is displayed, Providers must resubmit claims after maintenance is completed. If maintenance is not needed, Providers will be able to submit claims as usual during those hours. If any other scheduled maintenance is required outside of the published hours listed above, Caremark may notify Provider in advance.

Electronic Submission/Reversals/Processing Windows

Unless otherwise agreed in writing and to the extent permissible by applicable Law, all claims must be submitted electronically through the applicable claims system. Failure to submit a claim within 30 days from the date of fill may result in nonpayment of such claim.

All prescriptions not received by an Eligible Person must be reversed in accordance with the Provider Manual through the electronic claims system using data elements as defined by Caremark's payer sheet(s) or as directed Caremark.

For business other than Medicare Part D, Provider must reverse claims within 90 days from date on which claim was originally submitted, including client-specific payment cycles, and Provider must reverse and resubmit a claim within 30 days in which the claim was originally submitted. For Medicare Part D processing window specifics, please consult the **Medicare Part D** section in this Provider Manual.

Except to the extent permissible by applicable Law, Caremark does not accept universal claim forms (UCFs) or other forms of submission or reversal (i.e. cartridge, CD-ROM, tape, batch or paper) unless prior written approval is received from Caremark and/or Plan Sponsor, as applicable. A Provider handling fee of $2.00 per claim will apply in those situations in which Caremark and/or Plan Sponsor agree in writing to non-electronic submission and/or reversal of claims.

Transaction Fees

For every single claim transaction Provider transmits to Caremark, Caremark charges a minimum fee of $0.12 per transaction. These fees will be immediately due and owing by Provider to Caremark, and Caremark has the right to deduct such amounts from any amounts payable to the Provider. A single claim transaction means each claim, reversal, reject, resubmission, eligibility inquiry, or other electronic communication transmitted to Caremark through the claims system. A multi-claim transaction will be subject to a minimum fee of $0.15.

Software Certification

Provider must utilize software certified by Caremark and adhere to the National Council for Prescription Drug Programs (NCPDP) standards in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Provider must support NCPDP updates as requested from time to time by Caremark.

Caremark may provide reasonable technical support to assist Provider in complying with Caremark requirements and industry standards for submitting claims through the claims system. Provider may be assessed a fee by Caremark if Provider submits claims that are not in accordance with current requirements and industry standards.

If Provider is not submitting claims in accordance with HIPAA-mandated data and/or standards after October 16, 2003, Caremark may charge an additional fee, not to exceed $0.99 (99 cents) per transaction.

Data Fields and Submission Requirements

Please carefully review the payer sheet provided in **Appendix A** since the submission of certain optional data elements in NCPDP Version 5.1 is required by Caremark's Plan Sponsors and must be submitted for processing. Home infusion providers must certify their ASC X12N 837P software with Caremark prior to claim submission. Please refer to **Appendix B** for additional information regarding 837 submission requirements.

National Drug Code (NDC)

Provider must include all 11 digits of the correct NDC number as dispensed even if the manufacturer of the product only indicates 10 digits. The NDC must be provided in a 5-4-2 format. Provider must zero fill to the left when a number has been excluded from the format.

Prescriber Identification

Identification of the Prescriber requires a National Provider Identifier (NPI). If an NPI is unavailable at the time of claims submission, then Provider must submit using the following order of preference:

- the Prescriber Drug Enforcement Administration (DEA) number
- the hospital or affiliated clinic NPI or DEA
- Provider's own NPI or DEA for prescriptions for noncontrolled substances

Provider may use another designation for the Prescriber only when required and communicated by Caremark and/or Plan Sponsor. Provider must maintain the DEA number on the original hard copy for all controlled substances in accordance with state and federal laws.

Compounded Medications

Provider is encouraged, if providing compound medications as a routine business practice, to obtain accreditation through the Pharmacy Compounding Accreditation Board (PCAB). Provider is expected to maintain quality compounding practices in accordance with applicable Law, and standards of practice.

Provider shall submit compounds for reimbursement detailed by this Provider Manual. Provider shall not separate cash and third-party prescription business or own, operate, or affiliate with a nonparticipating provider to manipulate the compound pricing for inappropriate financial gain. Provider may be removed from participation in Caremark's network if Caremark reasonably determines, at its sole discretion, that Provider has taken actions to manipulate compound pricing for inappropriate financial gain.

Listed below are the requirements for Provider to submit claims for compounded medications.

- All compounds must be submitted **on-line**
- A **legend drug** must be one of the items in the compound and have a valid NDC
- Change the **compound indicator (compound code)** in the claim segment to identify the prescription as a compound

Single-Ingredient Processing:

- If utilizing single ingredient processing enter the **highest priced legend drug** – determined by multiplying the unit cost of each legend ingredient by its quantity in the compound and reporting the most expensive legend ingredient's NDC (Product/Service ID) in the claim segment (the primary NDC should not be altered to another NDC in the product if claim is rejected)
- Enter the **total quantity of the final product dispensed** in the quantity dispensed field in the claim segment
- Enter the **calculated cost of the complete compound as the ingredient cost submitted** in the pricing segment - This calculated total cost should be no greater than the combined AWP cost of all ingredients plus nominal professional allowance based on the level of effort. Caremark, at its sole discretion, will have final reasonable determination of professional allowance attributed to claim above the cost.

Multi-Ingredient Processing:

- Compounds should be submitted utilizing **multi-ingredient** functionality as required by the Plan Sponsor and/or communicated by Caremark to Provider (if Caremark has not communicated necessity of the multi-ingredient compound segment, please maintain the NDC of the primary as described in the Single-Ingredient Processing guidance detailed above)
- Enter the NDC (Product/Service ID) value of "0" in the claim segment (also enter the corresponding qualifier (Product/Service ID Qualifier) as "00".
- Enter the **dosage form of the final product dispensed** in the compound segment (must be a valid NCPDP compound segment dosage form value)
- Enter the **total quantity of the final product dispensed** in the quantity dispensed field in the claim segment
- Enter the **calculated cost of the complete compound as the ingredient cost submitted** (This calculated total cost should be no greater than the combined AWP cost of all ingredients plus nominal professional allowance based on the level of effort. Caremark, at its sole discretion, will have final determination of professional allowance attributed to claim above the cost.)
- Enter the **quantity of each individual compound ingredient product dispensed** as the compound ingredient quantity in the compound segment.
- Enter the **calculated cost of each individual compound ingredient** as the compound ingredient drug cost in the compound segment
- Enter the **level of effort** in the DUR/PPS segment (level of effort should be based on the table on page 11, unless otherwise communicated by Caremark)

Additional information concerning all compounded medications:

- Compounds that have a commercially available product are not reimbursable unless the product is not available in the marketplace. If the product is not commercially available, Provider should enter an ingredient cost submitted no greater than the cost of the commercial product and in accordance with guidance detailed in this

Provider Manual [Provider must document the necessity of dispensing the compound (i.e. invoice documenting the unavailability in the market, etc.)

- All compound recipes are subject to audit review. Full recipe disclosure is required for accurate calculation and must be provided to Caremark upon request.
- Calculated cost may not include cost of drug product associated with waste, unless the wasted drug product was not able to be utilized in the creation of additional compounded medications

The following medications should not be adjudicated as a compound and will not be reimbursed as such:

- A combination of products which are not combined to make one final medication for use (i.e. a 'kit' of individual products designed to be used independently)
- A combination of legend (and/or non-legend) products which do not have a medical purpose in combination other than convenience dosage form (example: legend and vitamin products combined into single dosage)
- A commercially available compound kit or commercially available product which is represented by a unique assigned NDC and contains all the ingredients of the final product as such (e.g., kit containing a base and active ingredient and directives for mixture, etc.)
- Compounds dispensed for human consumption which include ingredients that are not approved for human use
- Medications requiring reconstitution prior to dispensing (e.g., powdered oral antibiotics, topical acne preparations, etc.)
- Flavoring of a commercially available product prior to dispensing (e.g., addition of flavor to a powdered oral antibiotics, etc.), nor should the ingredient cost submitted include flavoring cost

LOE RATING	COMPOUND TYPE
1	Single Ingredient Batched Capsule
	Any Combination of Commercially Available Products
2	Two or Three Ingredient Batched Capsule
	Transdermal Gel
3	Four or More Ingredient Batched Capsule
	Three or Less Ingredient Cream/Ointment/Gel
	Three or Less Ingredient Capsule
	Suppository
	Two or Less Ingredient Troche
	Noncomplex Suspension
	Tablet Triturate
4	Topical Containing Controlled Ingredient
	Three or More Ingredient Troche
	Four or More Ingredient Cream/Ointment/Gel
	Four or More Ingredient Capsule
	Complex Suspensions (i.e. pediatric)
	Custom Capsule (Includes Rapid Dissolution Preparations)
	Chemotherapy Cream/Ointment/Gel
	Hormone Therapy (capsules, Troches, and Suppositories)
5	Sterile Product

Quantity Dispensed

Provider must enter exact metric decimal quantity dispensed only (no rounding) on all claim transactions. Many products are transmitted as a kit, the volume of medication, or weight in grams. Provider should review claims submission to ascertain that the quantity is accurate on all claims based on the specificity of the product and Prescriber instructions.

Strength Dispensed

Provider must utilize the strength originally prescribed by the Prescriber or use an available higher strength single dose of the same medication as described in the Dose Optimization program description located in the **Clinical Program, Services and Related Messages** section of the Provider Manual. Provider may not utilize a lesser strength in an increased quantity without documentation of unavailability of the prescribed strength.

Dispense As Written (DAW) Codes

To ensure proper payment to Provider and the correct Patient Pay Amount of Eligible Persons, all claims must be submitted with the accurate DAW code. Provider must select from the following codes:

DAW 0—No Product Selection Indicated

- Use DAW 0 when dispensing a generic; that is, when no party (i.e., neither Prescriber, nor pharmacist, nor Eligible Person) requests the branded version of a multisource product
- Use DAW 0 when dispensing a single-source brand product
- Generic pricing may be applied to claims for multisource products submitted with DAW 0

DAW 1—Physician Requested Product Dispensed As Written

- Must be evidenced on the prescription hard copy (original and updates) and used only when the **Prescriber** specifies the branded version of a multisource product on the hard copy prescription or in the verbally communicated instructions
- Computer systems that default to DAW 1 may result in discrepancies and chargebacks
- Prescription must follow state substitution Laws

DAW 2—Substitution Allowed—Patient Requested Product Dispensed

- Must be submitted when the **Eligible Person** requests the branded version of a multisource product even though a generic is available and the Prescriber has authorized (or not prohibited) a generic, or when the Eligible Person requests that Provider contact the Prescriber to obtain approval for a branded version when neither the original prescription nor the verbally communicated instructions specified the branded version
- Many plans require the Eligible Person to pay the difference between the brand and the available generic

DAW 3—Substitution Allowed—Pharmacist Selected Product Dispensed

- Generic pricing will be applied to claims for multisource products submitted with DAW 3

DAW 4—Substitution Allowed—Generic Not In Stock

- Generic pricing will be applied to claims for multisource products submitted with DAW 4

DAW 5—Substitution Allowed—Brand Dispensed As Generic, Priced As Generic

- Use DAW 5 when dispensing a branded version of a multisource product as a generic
- Generic pricing will be applied to claims for multisource products submitted with DAW 5

DAW 6—Not in use at this time

DAW 7—Substitution Not Allowed—Brand Mandated By Law

- Use DAW 7 when Law or regulations prohibit the substitution of a brand product even though generic versions of the product may be available in the marketplace

DAW 8—Substitution Allowed—Generic Not Available

DAW 9—Not in use at this time

Taxes

Notwithstanding any other provision in the Provider Agreement to the contrary, if any taxes, assessments, sales taxes and/or similar fees (collectively "Taxes") are imposed by any governmental authority on account of, or based upon, the provision of Pharmacy Services and Covered Items, the Eligible Person may be directly charged, in addition to any applicable copayment, coinsurance or deductible, the amount of such Taxes, unless specifically prohibited from doing so under applicable Law; provided, however, that if the applicable governmental authority otherwise compensates Provider or makes Provider whole for any such Taxes, Provider shall not be authorized to charge said amount directly to the Eligible Person.

Provider shall be responsible for submitting the appropriate Taxes, whether flat and/or percentage sales tax, for claims requiring such tax inclusion. In no event shall Caremark be responsible for any Taxes or other liability that may be imposed on Provider. Provider shall assume the responsibility of making, and shall make, payments to the appropriate taxing authorities of the amounts of any Taxes received.

In no event does this section give Provider any additional rights than those allowed by Law.

Long-term Care Billing

For Providers providing home health care or long-term care Covered Items to Eligible Persons, each NDC number of the individual drug dispensed must be billed only once to Caremark during any 30 day period unless allowed by Plan Sponsors. Provider must credit Caremark for any unused medications in accordance with the claims adjustment process and all applicable Laws. Provider agrees to submit claims to Caremark's claims adjudication system for Long-term care Pharmacy Services. Provider agrees to bill Caremark monthly for medications dispensed continuously over the course of a month. One dispensing fee will be paid based on the monthly quantity dispensed of a single drug of a single strength. When the medical needs of the Eligible Person require a change in the medication order or the medication provided has

a documented medical necessity for limited dispensing (including but not limited to expiration of product) requiring an additional dispensing of the same drug. Provider may receive one dispensing fee for each new medication order or dispensed-quantity limited by medical necessity.

Claims Requiring Overrides

Caremark has developed general prior authorization numbers for some Plan Sponsors for claims that are rejected.

A Help Desk representative can check to see if an override can be submitted to allow for the claim to adjudicate. In addition, some Medicaid Plan Sponsors do provide temporary coverage of nonformulary medications. If this is the case, the claim may reject with a message that includes the temporary days supply that will be covered and the prior authorization number to enter into the NCPDP prior authorization number field in order for the claim to adjudicate. Provider should calculate appropriate quantity for Covered Item accordingly to correspond with prescription instructions and temporary days supply.

Submission Error Codes

Caremark utilizes the NCPDP submission error codes. Please refer to **Appendix C** for a listing of Version 5.0 Reject Codes.

Network Participation and Payment

Provider Participation

Caremark may make available to Provider the opportunity to participate in Caremark or Plan Sponsor networks. Provider will be deemed to have accepted participation and reimbursement rate in any Caremark or Plan Sponsor network in which Provider adjudicates a claim for an Eligible Person in that network. Notwithstanding any prior agreements, the Agreement applies to all transactions under any network or Plan.

Provider Payment

Notwithstanding any other provision in the Provider Agreement, in the event of a conflict between the reimbursement rate indicated through the adjudication claims system and a network enrollment form or addendum, the adjudication claims system reimbursement rate will apply provided there is no error in the adjudication claims system resulting in overpayment to Provider and/or Eligible Person.

Caremark may pay Provider utilizing a Price Type. Claims submitted for a Plan Sponsor participating in a Caremark or Plan Sponsor network will be reimbursed at the lower of: (i) Price Type plus an applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, plus the applicable Dispensing Fee less the applicable Patient Pay Amount (or if applicable Price Type is unavailable for a given drug, Caremark will pay Provider based upon AWP minus the applicable AWP Discount plus the applicable Dispensing Fee minus the applicable Patient Pay Amount); (ii) MAC plus the applicable Dispensing Fee less the applicable Patient Pay Amount; (iii) ingredient cost submitted by Provider plus the applicable Dispensing Fee less the applicable Patient Pay Amount; or (iv) Provider's U&C price less the applicable Patient Pay Amount. The applicable Price Type plus an applicable percentage of the Price Type, or minus the applicable percentage of the Price Type, and the applicable Dispensing Fee may be set forth in a network enrollment form, network addendum, or transmitted on-line via the adjudication claims system.

Eligible Person Fees/Amounts

Provider must collect at the point-of-service from Eligible Persons any administrative, transaction, access or other types of such fees or amounts, when applicable. The total amount to collect from the Eligible Person for providing Pharmacy Services related to a Covered Item, including any such fee or amount, will be communicated through the claims system and may be debited from Provider's claims payment account.

Claims Payment

Remittance Advices

Provider will receive a remittance advice for claim transactions within a payment cycle. Such reports may be distributed by mail, posted on one of the Caremark websites, or by other electronic means.

If Provider or authorized agent of Provider requires additional remittance reports, the following service fees will apply:

REMITTANCE ADVICES SERVICE TYPE	MIMINUM SERVICE FEE
Paper remittance reprint	$50/NCPDP number
Internet, NDM, etc., data recreate	$100/item
Research Fee associated with no change in reimbursement	$75/hour
Check trace/stop payment	$75 per check

If Provider is receiving pharmacy remittance electronically, Provider must adhere to HIPAA regulations which mandate ASCX12N 835 and updates as required. Providers with questions regarding the testing, creation and receipt of the 835 data file should contact Caremark at the following address:

Caremark
Attn: Electronic Data Delivery, MC 122
9501 East Shea Boulevard
Scottsdale, Arizona 85260

Disputed Claims

If Provider disputes a claim due to alleged error, miscalculation, discrepancy or questions the accuracy of any claim, Provider must notify Caremark in writing, listing details of the disputed claim payment or adjustment, including claim detail (date of fill, prescription number, Eligible Person ID number, Pharmacy number – NPI or NCPDP – include a copy of the remittance advice, if possible, and reason why an adjustment is needed – e.g., was wrong quantity submitted,

was wrong NDC submitted, etc.). If Provider fails to advise Caremark in writing of any alleged error, miscalculation, discrepancy or basis for questioning the correctness of any claim within 120 days of date of fill, Provider will be deemed to have confirmed the accuracy of the processing and payment of claims as set forth in the report for that cycle. This does not apply with respect to any overpayments made to Provider.

Caremark may charge a research fee of $75/hour for any request in which Provider was accurately reimbursed.

Caremark is not obligated to reimburse Provider, on behalf of a Plan Sponsor, for a claim if Provider has breached any of the provisions or terms set forth in the Provider Agreement with respect to that claim. Any overpayments made to Provider may be deducted from amounts otherwise payable to Provider. See **Professional Audit** section for additional information on audits.

To request an adjustment to a claim, Provider must timely submit to Caremark sufficient documents and records to substantiate that the claim was paid incorrectly. Such adjustment requests may be mailed to:

Caremark
Attn: Claims Processing, MC 128
9501 East Shea Boulevard
Scottsdale, Arizona 85260

Claims Adjustment

Caremark may adjust paid claims to correct errors or reflect changes in Eligible Person information, to the extent permissible under applicable Law.

Directories

Provider must allow Caremark and Plan Sponsors to list Provider in applicable directories and databases for distribution and use by Eligible Persons, Plan Sponsors and others as determined by Caremark and/or Plan Sponsors. Additionally, Caremark may display Providers that participate in preferred provider performance initiatives foremost in paper and Web-based directories and in Plan Sponsor reporting.

Provider Suspension

Caremark may immediately suspend, pending further investigation, the participation status (which may include temporary payment withholding, or claims adjudication suspension) of Provider if Caremark has reason to believe that Provider has engaged in, or is engaging in, behavior that (i) appears to pose a significant risk to the health, welfare, or safety of Eligible Persons or (ii) does not meet the quality management standards to serve as a provider for Caremark or its Plan Sponsors.

Caremark's ultimate remedies under this section includes termination of the Provider Agreement.

Provider Termination

Termination for Cause

If Provider fails to meet any of the credentialing requirements or breaches any of the terms set forth in the Provider Agreement, Caremark may immediately terminate the Provider Agreement.

Provider must abide by the provisions and terms set forth in the Provider Agreement. Nonadherence to any of the provisions set forth in the Provider Agreement, which includes the Provider Manual, Addendum, and other Caremark Documents, will be deemed a breach of the Provider Agreement and subject to immediate termination and other remedies.

Caremark may immediately terminate the Agreement if: (i) unless otherwise precluded by Law, Provider makes an assignment for the benefit of creditors, file a petition in bankruptcy (whether voluntary or involuntary), is adjudicated insolvent or bankrupt, a receiver or trustee is appointed with respect to a substantial part of its property or a proceeding is commenced against it which will substantially impair its ability to perform the Agreement; (ii) any court, governmental, or regulatory agency issues to Provider an order to cease and desist from providing Pharmacy Services; (iii) ownership of Provider is transferred to a new owner, or if the right to control the operation of the business of Provider is transferred to a different person or entity; or (iv) a levy, writ of garnishment, attachment, execution or similar item is served upon Provider and not removed within ten (10) days from the date of service.

These termination rights are in addition to any and all other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity.

Termination without Cause

Caremark may at any time terminate the Provider Agreement without cause upon notice to Provider or such longer time as required by Law.

Caremark may terminate Provider from participating in providing Pharmacy Services to specific Plans without cause upon a notice to Provider, regardless of the network(s) in which Provider participates.

Provider may terminate the Provider Agreement without cause upon thirty (30) days' prior written notice to Caremark, provided however, that if applicable Law or a Caremark national network, a Plan Sponsor network, or Plan participating in the RECAP® network requires a longer notice period, the Provider Agreement shall not terminate until the expiration of such longer period. Except as otherwise may be required with respect to any Caremark national network, Plan Sponsor network, or Plan participating in the RECAP® network, Provider may terminate participation in any Caremark national network, a Plan Sponsor network, or Plan participating in the RECAP® network by giving Caremark thirty (30) days' prior written notice specifying the date of termination and the names of the network(s) or Plan(s) in which Provider will no longer participate. Absent the prior written consent of Caremark, Provider may not elect to participate in a Caremark national network, a Plan Sponsor network, or Plan participating in the RECAP® network for thirty (30) days following Provider's termination of participation in such network or Plan.

The terms of this **Termination Without Cause** section apply notwithstanding any other provision in the Provider Agreement.

Rights and Remedies in the Event of Termination or Breach

In the event of a termination of the Provider Agreement with Caremark for any reason, Provider must surrender the Provider Agreement, Provider Manual, and any and all other Caremark Documents and any other materials related to products, programs, services, and Plan Sponsor announcements provided by Caremark to Provider or in Provider's possession or control.

In the event Provider breaches any provision of the Provider Agreement, in addition to all other termination rights, Caremark shall have the right to (i) suspend any and all obligations of Caremark under and in connection with the Provider Agreement, (ii) impose reasonable handling, investigation and/or improper use fees, and/or (iii) offset against any amounts owed to Provider under the Provider Agreement (including amounts that are paid to Caremark on behalf of a Plan Sponsor) or under any other agreement between Caremark and Provider, any amounts required to be paid by Provider to Caremark. These rights and remedies are in addition to any and all other rights and remedies that may be available to Caremark under the Provider Agreement or at Law or equity.

Survival of Certain Provisions

Notwithstanding the termination of the Provider Agreement, Provider obligations that arise prior to the termination of the Provider Agreement shall survive such termination.

Clinical Programs, Services and Related Messages

Provider must support all clinical programs and services, and utilize software that will display all messages related to clinical programs and services and that provide for the recording of patient drug and medical information, where utilized by Caremark and as allowed by applicable Law.

Subject to applicable Law, Provider must provide Caremark any and all reasonably available information that Caremark needs to perform such clinical programs and services, and conduct drug utilization review accordingly.

Provider must act upon all messages related to clinical programs, subject to professional judgment.

Generic Drug Standards

Provider must dispense a generic drug whenever permitted and in accordance with applicable Laws.

Provider must use its best efforts to carry out Caremark and Plan Sponsor mandatory generic programs. In doing so, Provider must contact the Prescriber to encourage a change to a generic substitute when the prescription contains a "dispense as written" signature for a multisource brand medication.

Provider must stock a sufficient amount of drugs under their generic name coinciding with the habits of local Prescribers, the Caremark and/or local Plan Sponsor formulary(s) as indicated by the claims system response and other correspondence, or the generic formulary of the State in which the Provider resides.

When a multisource brand medication is dispensed, Provider must submit the correct "dispense as written" code as set forth in the section entitled "Dispense as Written" Codes in the **Pharmacy Services and Standards** and **Professional Audit** sections of the Provider Manual, unless otherwise specifically directed by Caremark.

Drug Utilization Review

Inappropriate drug therapy can cause patient injury and can lead to additional health care costs. In an effort to reduce the number of situations where an Eligible Person may receive inappropriate drug therapy, Caremark implemented a concurrent drug utilization review (DUR) program that detects a potential therapeutic problem at the point of service.

Provider must adhere to claims submission requirements outlined in the *Claims Submission* section of the Provider Manual. Provider must submit all claims for Pharmacy Services related to Covered Items for Eligible Persons electronically through the applicable claims system.

The functions of the DUR program are to:

- Analyze prescriptions submitted through Caremark
- Screen prescriptions for several types of therapeutic drug problems
- Serve as a clinical information service

The DUR program is not intended to replace the knowledge, expertise, skill, and sound professional judgment of the Provider or Prescriber. The Provider is responsible for acting or not acting upon the DUR information generated and transmitted through the claims system and for performing Pharmacy Services in each jurisdiction consistent with the scope of their respective licenses.

Drug use inconsistent with the Caremark DUR criteria may be appropriate in certain clinical settings.

DUR Conflict Codes and Text Messaging

All DUR messages appear in the claim response. The Provider must view all screens necessary to receive the message detail, and act upon all such messages subject to the professional judgment of Provider.

Provider will receive the DUR message in a format consistent with its software vendor. Provider may need to consult with the software vendor for help with identifying or accessing DUR messages. Caremark, in accordance with current NCPDP standards, returns up to nine DUR messages that can be received on the same claim and requires Provider to have the capability to accept up to nine DUR messages on the same claim.

Following are some of the most commonly used DUR conflict codes and messages with corresponding descriptions separated into categories as recommended by NCPDP.

Sample Dosing and/or Limits Categories

CONFLICT	CONFLICT CODE	TEXT MESSAGE	DESCRIPTION
High Dose	HD	Maximum Dose <XX> Units/Day	Detects a drug dose that falls above the standard dosing range.
Excessive Utilization (Early Refill)	ER	Previous Rx <XX> Days Supply	Detects prescription refills that occur before the days' supply of the previous fill should have been exhausted
Under Utilization (Late Refill)	LR	Last Refill <XX> Days MM DD	Detects prescription refills that occur after the days' supply of the previous fill should have been exhausted

Drug Interaction Category

CONFLICT	CONFLICT CODE	TEXT MESSAGE	DESCRIPTION
Drug-Drug Interaction	DD	<History Drug>	Identifies drug combinations where the pharmacological response is different from the expected result when each drug is given separately

Duplicate Therapy Category

CONFLICT	CONFLICT CODE	TEXT MESSAGE	DESCRIPTION
Therapeutic Duplication	TD	<History Drug>	Detects simultaneous use of drugs from the same therapeutic class
Ingredient Duplication	ID	<History Drug>	Detects simultaneous use of the same drug in different strengths or dosage forms

Drug Conflict Category

CONFLICT	CONFLICT CODE	TEXT MESSAGE	DESCRIPTION
Drug Age Precaution	PA	Caution For Ages </> XX	Detects when the patient age falls within the contraindicated age range
Drug Pregnancy Alert	PG	Teratogen-Verify Not Pregnant	Identifies drugs that are considered contraindicated during pregnancy
Drug Disease Precaution	DC	Possible <Disease Name>	Provides contraindication and warning messages concerning the use of certain drugs in patients with specific medical conditions. The medical condition is inferred from previously prescribed drugs.

Precautionary Category

CONFLICT	CONFLICT CODE	TEXT MESSAGE	DESCRIPTION
Call Help Desk	CH	<Help Desk Phone Number>	Used if more than two DUR problems exist or if DUR problems require supplemental messages

NOTE: Help Desk personnel are qualified only to provide the complete DUR message and supporting claim data. Professional support—i.e., clinical drug consultation, assistance with intervention decisions, alternative therapy recommendations, etc.—is not available from the Help Desk. It is important to thoroughly document DUR-related actions and subsequent Prescriber comments and instructions.

Refill Too Soon or Excessive Utilization Reject

Provider must call the Help Desk if extenuating circumstances justify payment for a claim that was denied for excessive utilization (REFILL TOO SOON). This may occur in situations such as:

- Lost or stolen prescriptions
- Dropped or broken prescription bottle (liquids)
- Vacation supplies
- Increase in dosing
- Circumstances such as natural disaster

Drug-Drug Interaction Rejects Program

The Drug-Drug Interaction Rejects Program is a point-of-sale claim reject for selected high-risk drug combinations. The reject will occur if the current drug being submitted and another drug that was dispensed to the Eligible Person are one of the high-risk drug combinations included in the program.

When a claim is rejected for a high-risk drug-drug interaction, a standard drug-drug interaction warning message will be transmitted with the claim reject response. In addition, a secondary message will be transmitted that provides instructions regarding override options. Depending on the types of override that the Caremark Plan Sponsor has authorized, one of the following override option messages will be transmitted:

CHECK DUR – OVERRIDE W/ PA <XXXXXXXXXXX>

In this case, Provider may resubmit the claim with the indicated PA code to override the reject, based on the professional judgment of Provider and in consultation with the Prescriber.

PA REQUIRED – <ADDITIONAL INSTRUCTIONS APPEAR HERE>

In this case, a prior authorization is required to override the reject. The message will provide further instructions on how to obtain an override.

Provider must contact the Prescriber to discuss the drug-drug interaction that has been identified for the current prescription based on the Eligible Person's other active drug therapy. If the Prescriber determines that the prescribed therapy is warranted despite the drug-drug interaction risk, or if the interacting drug has been discontinued, the Provider must pursue an override according to the instructions provided in the claim response message. Otherwise, Provider should obtain a new prescription for an alternative therapy.

Formularies

Caremark develops and assists Plan Sponsors in developing formularies that achieve desirable clinical outcomes and help control overall health care costs. Formularies are provided as a reference for drug therapy selections. The final choice of specific drug selection for an Eligible Person rests solely with the Prescriber.

Provider must support all formulary initiatives and inform Eligible Persons when a nonformulary drug has been prescribed and use best efforts to contact the Prescriber to encourage formulary compliance. Provider agrees that for all Plan Sponsors and its Eligible Persons, therapeutic programs and formularies take precedence over any agreements or programs to which Provider is a party. Provider also agrees not to implement any substitution programs for Eligible Persons that are inconsistent with such programs.

When a claim is submitted for a nonformulary drug and the Plan has a closed formulary, it may reject with:

NDC NOT COVERED

When a claim is submitted for a nonformulary drug and the Plan has an open formulary, the response may include the message:

NF !FORM <XXXX>

In many cases, the Patient Pay Amount may be higher for a nonformulary medication.

Prior Authorization

For some Plans, certain medications will require prior authorization. For prior authorization, the Prescriber needs to supply additional documentation to Caremark or the Plan Sponsor to determine whether certain criteria are met for the drug to be covered under the Plan.

If a medication is designated for prior authorization, the claim will reject with the following message:

PRIOR AUTHORIZATION REQUIRED
MD CALL <XXX-XXX-XXXX>

In most cases, the claims system response will also provide the correct contact information in the subsequent message. If the Prescriber feels the drug is medically necessary, he or she will need to call the number listed in the messaging to initiate coverage.

Provider must support all clinical programs and services and inform Eligible Persons when a drug designated for prior authorization has been prescribed. Provider must use its best efforts to contact the Prescriber to inform on prior authorization messaging.

Managed Drug Limitations/Quantity vs. Time

Some Plan Sponsors implement managed drug limitations (MDL) or quantity vs. time (QVT) programs. MDL or QVT allows an Eligible Person to receive up to a set amount of medication per designated timeframe.

If an Eligible Person presents a prescription for an amount greater than the set amount or has accumulated an amount greater than the set amount within the designated timeframe, the claim will reject with one of the following messages:

PLAN LIMITS EXCEEDED
OF QUANTITY LEFT*
OR
MAX QUANTITY XX PER XX DAYS

*If there is a remaining quantity, Provider can resubmit the claim using an amount equal to or less than the amount revealed in the message.

Performance Drug Program

Some Plan Sponsors implement the Performance Drug Program (PDP). Under PDP, Caremark pays a fee to Providers for services performed for discussing drug selection alternatives from the Caremark Performance Drug List (PDL) with the Prescriber and the Eligible Person. The Performance Drug List (PDL) is a clinically approved, economically modeled subset of Caremark's Prescribing Guide. PDL drugs that are part of the PDP are referred to herein as "Performance Drugs."

PDP has unique features:

- Caremark pays for services performed and Eligible Persons and Providers receive disclosure of the fact that fees are paid by Caremark to Provider for services rendered in support of the PDP
- Retail pharmacists play the central role
- The program steps are performed only at the request and with the support of Plan Sponsors
- The Performance Drugs are therapeutically equivalent and save money for the Plan Sponsor

Important: Participation is voluntary for Eligible Persons. Never tell the Eligible Person that a nonpreferred prescription drug is not covered.

General Information on the Performance Drug Program

With PDP, Providers become involved with both the Eligible Person and Prescriber, ensuring that a therapeutically equivalent and economically appropriate drug is selected.

PDP is an important program for Providers. By demonstrating that retail Providers can add value to a prescription benefit program through professional service, it is a step toward a future where the role of Provider emphasizes service over dispensing.

PDP is not a mandatory drug switching program, nor a closed formulary. **Instead, Caremark gives the Eligible Person a choice, and he or she must agree to participate.** In fact, Caremark requires the participating Provider to obtain the Eligible Person's authorization prior to contacting the Prescriber about dispensing a Performance drug.

Note: The PDL is a clinically approved, economically modeled subset of Caremark's Prescribing Guide that is designed to reduce a plan sponsor's overall long-term cost of its drug benefit. While certain Performance Drugs may be more "cost-effective" than their nonperformance drug counterparts, as evidenced by a low or average wholesale price (AWP), there are a number of other criteria which are evaluated in determining that a Performance Drug is less costly than a nonperformance drug.

PDP offers an additional source of income for Providers. Service payments range from $2.00, for discussing an alternative therapy with a Eligible Person, to $12.00 for completion of all services related to a successful intervention.

In many drug categories, Providers will find that Caremark has elected to make a generic alternative the "preferred" (or Performance) Drug, rather than a therapeutically equivalent branded product.

Disclosures to Eligible Persons

Providers must provide to each Eligible Person a copy of the tear-off sheet ("Tear-Off Sheet") —see **Appendix D**— that includes: (i) a description of the PDP, (ii) a disclosure that participation in the PDP is voluntary and that the Eligible Person may choose whether or not to participate, and (iii) that the Provider will be compensated for the time and effort spent discussing the program with the Eligible Person and the Eligible Person's Prescriber.

Disclosures to Prescribers

Providers must disclose to Prescribers: (i) that Caremark administers the Eligible Person's pharmacy benefit plan; (ii) that the Provider will be compensated for the time and effort spent discussing the program with the Eligible Person and the Eligible Person's Prescriber; (iii) the name and manufacturer of the originally prescribed drug and the suggested Performance Drug; and (iv) the name of the pharmacist.

Participation Guidelines

It is important to follow these guidelines, or Provider will not be allowed to participate in the Performance Drug Program.

To ensure success and avoid Eligible Person dissatisfaction, Caremark has developed the following procedures for participation:

STEP 1

All pharmacists and other personnel must have a clear understanding of PDP and PPS codes.

Most important: When the E4 reject (defined as the DUR conflict code) appears, the message !PDP OPPORTUNITY$$, will follow and the free-form text message field will indicate the Preferred Drug(s), i.e., !USE GENERIC LISINOPRIL.

Important: Participation is voluntary for Eligible Persons. Never tell the Eligible Person that a nonpreferred prescription drug is not covered.

Submit PPS codes indicating where your services stopped.

For example:

PS PE 3B (Eligible Person says "No")

PS MØ 3B (Prescriber says "No")

PS TH 1E (Performed intervention)

When an intervention is still in progress and Provider dispenses the nonpreferred drug (i.e., waiting for the Prescriber to call back), use PS TH ØØ to indicate that PPS codes will be submitted on the next claim.

STEP 2

PDP materials must be in Provider's store and available for use. These materials currently include PDP Eligible Person tear-off sheets, the Provider Manual and PPS code chart.

STEP 3

Provider can call **1-800-388-5666** in order to be activated into the PDP. The call will be returned within 24 hours.

Procedures for PDP

STEP 1

Accept the prescription and prescription ID card from the Eligible Person.

STEP 2

Submit the claim to be processed.

STEP 3

If the drug offers a PDP opportunity, the claim will be rejected with code E4 (defined as the DUR Conflict Code).

Important: Participation is voluntary for Eligible Persons. Never tell the Eligible Person that a nonpreferred prescription drug is not covered.

The message !PDP OPPORTUNITY$$ will follow. Once receiving that message, examine the free-form message fields to determine the nature of the opportunity for service. For example, if the prescription is for Prinivil (nonpreferred), the message will read, !USE GENERIC LISINOPRIL.

STEP 4

Go forward with the intervention based upon and using knowledge of the Eligible Person, clinical judgment and other relevant factors.

STEP 5

If Provider cannot follow up the opportunity immediately, resubmit the original claim and the PPS code: PS TH ØØ (Will submit PPS codes on the next refill).

STEP 6

Provider must explain the program to the Eligible Person and provide the tear-off sheet with the required disclosures. Ask whether he or she would like to participate. This is a voluntary program for the Eligible Person.

STEP 7

If the Eligible Person declines participation, enter the appropriate PPS codes PS PE 3B (Eligible Person said "No").

STEP 8

If the Eligible Person agrees, contact the Prescriber, explain the program, make all required disclosures, and discuss the alternatives.

STEP 9

If the Prescriber agrees, document the change on the prescription, counsel the Eligible Person and dispense the alternative drug. Send the new claim for the Performance Drug with the PPS codes PS TH 1E (Performed intervention).

STEP 10

If the Prescriber does not agree, fill the prescription for the nonpreferred drug. Submit the claim with the PPS codes PS MØ 3B (Prescriber did not agree).

Note: The Provider must comply with all applicable Laws in connection with its participation in the Performance Drug Program including, without limitation, Laws regarding the transfer of prescriptions and Laws regarding generic substitutions and therapeutic interchanges.

Important:

Always submit the original claim for all interventions. Caremark must be able to link the original claim and the new claim.

Always submit the appropriate PPS codes indicating where the service stopped.

PDP Fees

A service fee is paid for each step in the intervention process. The total of the different fees to be paid, in addition to normal dispensing fees, is transmitted at the time of service.

	SERVICE PERFORMED	SERVICE FEE
Step 1	**Deliver PDP information and Tear-Off Sheet to Eligible Person**	**$2.00**
	Discuss program with Eligible Person and disclose Provider compensation	
	Eligible Person agrees or does not agree	
	Send appropriate PPS codes	
Step 2	**Gain Prescriber approval for intervention**	**$2.00**
	Explain purpose of the call to the Prescriber and disclose Provider compensation and make other required disclosures	
	Prescriber agrees to interchange	
	Prescriber does not agree to interchange; fill/refill original prescription	
	Send appropriate PPS codes	
Step 3	**Review specifics of Eligible Person involved**	**$6.00**
	Answer additional Prescriber's questions about therapeutic issues applicable to this Eligible Person	
	Document Prescriber's instructions	
	Document new prescription and instructions on hard copy or computer	
Step 4	**Contact Eligible Person again**	**$2.00**
	Dispense Performance Drug	
	Send claim to Caremark with appropriate PPS codes	

Important: Participation is voluntary for Eligible Persons. Never tell the Eligible Person that a nonpreferred prescription drug is not covered.

Rules for Submitting Service Claims/Audit Requirements

To receive a service fee for performing the steps outlined above, the appropriate NCPDP PPS codes must be submitted along with the standard claim information. Once a payable service for a Eligible Person is submitted, Provider will not be eligible for another payment for that service—with respect to the Eligible Person and that therapeutic class—for two years.

For example, once codes, such as the Eligible Person said, "No," codes are submitted, the opportunity is suppressed for a two-year period of time. No E4 reject messages for this drug for this Eligible Person will be received. Follow up can occur later, if a Eligible Person changes his or her mind, and Provider can become eligible for additional service fees.

Documenting Services Performed

There are three acceptable ways to document services that are performed for PDP:

- A handwritten note on the original prescription indicating the service performed, the date, and the pharmacist who performed the service; documentation must allow Caremark to identify both the originally prescribed drug and the Performance Drug, if a change in therapy actually occurred
- An indication in the signature log that a service was performed using PPS codes (along with the service performed, the date and pharmacist involved)
- On-line documentation which includes identification of the service performed, the date and the pharmacist involved (this must be printable)

Guidelines for PDP Provider Compliance

Acts of misconduct will prompt a Provider's immediate removal from the PDP and referral to the Caremark Provider Membership Review Committee for consideration of whether or not continuing membership in all Caremark networks will be permitted.

Caremark actively monitors Provider compliance with the PDP and corresponding service fees.

Example— PRINIVIL TO GENERIC LISINOPRIL

When a Eligible Person presents a prescription for Prinivil, transmit the claim to Caremark. The system responds with an E4 reject and the following message:

!PDP OPPORTUNITY$$!USE GENERIC LISINOPRIL

Review the Eligible Person's profile and initiate a consultation, explaining PDP and providing the Tear-Off Sheet to the Eligible Person.

Important: Participation is voluntary for Eligible Persons. Never tell the Eligible Person that a nonpreferred prescription drug is not covered.

If the Eligible Person is not available to ask, pend the intervention (PS TH ØØ). Dispense the nonpreferred drug and discuss the Performance Drug with the Eligible Person when he or she picks up the prescription.

If the Eligible Person does not want to participate, submit the claim with the PPS codes PS PE 3B at the next refill.

If the Eligible Person agrees, continue the intervention process.

Next step: Call the Prescriber and explain the program and make all the required disclosures.

If the Prescriber does not want the Eligible Person to change medications, submit the claim with the PPS code PS MØ 3B. The Eligible Person will continue to use Prinivil.

If the Prescriber authorizes to the intervention, continue the process and dispense lisinopril to the Eligible Person.

Document the change in the prescription and counsel the Eligible Person. Submit the new claim with PPS code PS TH 1E.

Provider will be reimbursed $12.00 for completing all steps for this intervention.

Suggested Responses When Communicating with Eligible Persons

SCENARIO 1: ELIGIBLE PERSON AGREES

Eligible Person presents prescription to the pharmacist. The pharmacist decides, based on available clinical information, that the Eligible Person can be safely changed to a Performance Drug.

Eligible Person: *Can you fill this while I wait?*

Pharmacist: Sure. That shouldn't be a problem. Please take a seat and I'll call you when it's ready. (Pharmacist enters prescription into computer. Claim is rejected with code E4, indicating a PDP service opportunity.)

Pharmacist: Mr./Miss/Mrs._____, your prescription drug benefit plan is administered by Caremark. Your plan sponsor is participating in Caremark's Performance Drug Program; this (leaflet) will explain the program in more detail.

Did you know we can give you a Performance Drug if your Doctor agrees that it is therapeutically appropriate? This drug is listed on your Plan Sponsor's Performance Drug List. Through Caremark, your Plan Sponsor has asked me to ask you to consider permitting a change in your drug therapy, and is compensating this pharmacy for the extra time needed to talk about this program with you. Of course, the choice is yours. If you decide to decline, the originally prescribed drug will be covered under your benefit plan.

Eligible Person: *Well, I'm not sure. Did my Doctor say that I was supposed to have a certain brand?*

Pharmacist: Yes, he/she did, and I would be happy to call him/her to talk about the alternative medication that could be used for your condition.

[Go to Prescriber Script]

Pharmacist: Mr./Miss/Mrs._____. I spoke with your Doctor and he/she agreed that you may use the medication. (Pharmacist counsels Eligible Person.)

SCENARIO 2: ELIGIBLE PERSON DOES NOT AGREE

Eligible Person presents prescription to the pharmacist. The pharmacist decides, based on available clinical information, that the Eligible Person can be safely changed to a Performance Drug.

Eligible Person: *Can you fill this while I wait?*

Pharmacist: Sure, that's no problem. Please take a seat and I'll call you when the prescription is ready. (Pharmacist enters prescription into the computer. Claim is rejected with code E4, indicating a PDP service opportunity.)

Pharmacist: Mr./Miss/Mrs._____, your prescription drug benefit plan is administered by Caremark. Your plan sponsor is participating in Caremark's Performance Drug Program; this (leaflet) will explain in more detail. (Provide Tear-Off Sheet to Eligible Person)

Did you know we can give you a Performance Drug if your Doctor agrees that it is therapeutically appropriate? This drug is listed on your plan sponsor's Performance Drug List. Through Caremark, your plan sponsor has asked me to ask you to consider permitting a change in your drug therapy, and is compensating this pharmacy for the extra time needed to talk about this program with you.

Eligible Person: *No, I'm not interested. I've tried many different medications and they do not agree with me. Just fill the prescription as is.*

Pharmacist: That's fine. If you have any questions, please call me. Here is your prescription. (Pharmacist counsels Eligible Person.)

Suggested Responses When Communicating with Prescribers

SCENARIO 1: PRESCRIBER UNAVAILABLE

Eligible Person presents an original prescription to pharmacist. The pharmacist decides, based on available clinical information, that the Eligible Person can be safely changed to a Performance Drug. Eligible Person has agreed.

Pharmacist: Hi, this is (first name, last name) from XYZ Pharmacy calling to discuss a prescription written by Dr._____ for Mr./Miss/Mrs. _____.

Nurse (Receptionist): The Prescriber is busy with Eligible Persons now. May I take a message?

Pharmacist: Sure! The Eligible Person's full name is _____. The Eligible Person's drug benefit plan is administered by Caremark, a pharmacy benefit management company. I have just given the Eligible Person a printed explanation describing a special program that his/her Plan Sponsor endorses: the Caremark Performance Drug Program. The Eligible Person's Plan Sponsor, through Caremark, has asked me to ask the Doctor to consider permitting a change in the Eligible Person's therapy and is compensating this pharmacy for taking extra time to explain this program to the Doctor.

That's why I am calling to consult with Dr. _____ about a therapeutic alternative.

Please give the information to the Doctor. We'd like a call to talk about his/her prescription for Mr./Miss/Mrs. _____. Our phone number is _____.

SCENARIO 2: PHARMACIST SUCCESSFULLY CONTACTS PRESCRIBER

Eligible Person presents an original prescription to pharmacist. The pharmacist decides, based on available clinical information, that the Eligible Person can be safely changed to a Performance Drug. Eligible Person has agreed.

Pharmacist: Hi. This is (first name, last name) from XYZ Pharmacy calling to discuss a prescription written by Dr. _____ for Mr./Miss/Mrs. _____. The Eligible Person's full name is _____. The Eligible Person's drug benefit plan is administered by Caremark, a pharmacy benefit management company. I have just given the Eligible Person a printed explanation describing a special program that his/her Plan Sponsor advocates: the Caremark Performance Drug Program.

That's why I am calling to consult with Dr. _____ about a therapeutic alternative.

Please give that information to the Doctor. We'd like the Doctor to call us about his/her prescription for _____. Our phone number is _____.

Nurse: *Just one moment, please. If you will give me the Patient's name again (and possible additional information, such as address and date of birth), I can pull the chart for the Doctor to review.*

Pharmacist: Thank you. (Gives additional information as needed) We are calling about the prescription for brand name, generic name, manufacturer's name.

Doctor: *This is Dr._____. You are calling about _____?*

Pharmacist: Yes, Doctor, I understand that Mr./Miss/Mrs. _____ is currently prescribed brand name, generic name, manufacturer's name. Under Mr./Miss/Mrs. _____ pharmacy benefit plan, we see there is a Performance Drug that we would like you to consider. The Eligible Person's drug benefit plan is administered by Caremark, a pharmacy benefit management company. The Eligible Person's Plan Sponsor, through Caremark, has asked me to ask you to consider permitting a change in the Eligible Person's therapy and is compensating this pharmacy for the extra time needed to discuss the program with you and your Patient. Would it be all right to substitute (brand name, generic name, manufacturer's name for brand name, generic name, manufacturer's name)? Your Patient has authorized us to call you.

ANSWER 1

Doctor: *Yes, but I would like to review the Patient's chart. Mr./Miss/Mrs. _____ is currently taking (name of drug) and I want to make sure that your recommendations will not interfere with his/her current medications.*

Pharmacist: Please do so.

Doctor: *I don't see any potential problems with changing this Patient's therapy to (name of Performance Drug). You may go ahead and give him/her (name of Performance Drug) to be taken _____ (dosage, frequency, other instructions).*

Pharmacist: Just to confirm, Doctor, we are going to substitute (name of Performance Drug) for (name of original drug).

ANSWER 2

Doctor: *No, there's good reason not to change this Patient.*

Pharmacist: Thank you, Doctor. We will dispense the prescription as you indicated. I appreciate your time.

Explanation of PPS codes

PPS CODES	DESCRIPTION	COMMENTS	OTHER
PS PE 3B	Eligible Person said "No"	After consultation, Eligible Person does not want to participate.	Service fee: $2.00 for Eligible Person consultation. You are not eligible for this service for this Eligible Person in the therapeutic category for 2 years
PS MØ 3B	Prescriber said "No"	Eligible Person agrees, but Prescriber does not want to change therapy.	Service fee: additional $2.00 for contacting Prescriber. You are not eligible for another payment for this service for this Eligible Person in the therapeutic category for 9 months
PS TH 1E	Performed intervention	Prescriber agreed to intervention and you successfully changed the Eligible Person's therapy.	Service fee: additional $8.00. You are not eligible for another payment for this service for this Eligible Person in the therapeutic category for 9 months
PS TH ØØ	Will submit PPS on next refill	The intervention is not complete OR you plan to intervene later (i.e., you await the Prescriber's return call).	On the next fill, the claim will be rejected to alert you to indicate what service has been performed.

Performance Drug Program PPS Codes

DESCRIPTION	REASON	SERVICE	RESULT
Eligible Person said "No"	PS	PE	3B
Prescriber said "No"	PS	MØ	3B
Performed intervention	PS	TH	1E
Will submit PPS codes on next refill; intervention pending	PS	TH	ØØ

PDP Interventions

Because the interventions may change periodically throughout the year, it is important to look at the reject message. After an E4 reject, the DUR message will announce a PDP opportunity. Access the free-form text for the specific intervention. For example, if you transmit a Vasotec claim that is rejected, you will receive the following message in the free-form text:

!USE GENERIC ENALAPRIL

****Never* tell the Eligible Person the original drug is not covered**

****This is a *Voluntary* program for the Eligible Person**

Providers may call Caremark Network Performance at 1-800-388-5666 to inquire about PDP.

Dose Optimization

Dose Optimization is a point-of-service claim reject for selected drugs where multiple daily doses of the drug are prescribed and where a higher strength single daily dose is available and clinically appropriate. For example: Lipitor 10 mg 2 tabs/day could be optimized to Lipitor 20 mg 1 tab/day.

For a drug subject to Dose Optimization, the claim will reject (Reject 19 – Missing/Invalid Days supply), with the following message:

USE HIGHER STRENGTH ONE PER DAY

In the event there is an override option, the subsequent message will state what to do:

CALL HELP DESK <or a specific Plan Sponsor telephone number>

Provider must contact Prescriber for a new prescription of a higher strength at the once-daily dosing regimen, then resubmit the claim with the higher strength. If this cannot or should not be done based on the professional judgment of Provider or the Prescriber is unwilling to change the prescription, review Provider messaging for further instructions.

Prerequisite Step Therapy

Prerequisite Step Therapy requires that a set quantity of certain medication(s) be in an Eligible Person's drug history within a given timeframe before a claim will adjudicate for another drug in a specified therapeutic category. For example, a 30-day supply of a generic H_2 antagonist must be in the Eligible Person's drug history within the last 120 days for the Eligible Person to obtain a proton pump inhibitor.

The following therapeutic categories are currently being recommended by Caremark to Plan Sponsors as initial Prerequisite Step Therapy. Plan Sponsors may implement any or all of these therapeutic categories as well as adapt similar criteria to other therapeutic categories.

PROTOCOL	QUALIFIERS	HISTORY DRUG LIST (HDL)		CLAIM DRUG LIST (CDL)
ACNE '1 line Acne B4 Tazrc'	2 history drugs 14 day supply each 180 days history	**Topical Antibiotics** clindamycin erythromycin sulfacetamide/sulfur sulfacetamide	**All Rx benzoyl peroxide products** **Oral Antibiotics** tetracycline minocycline doxycycline	Tazorac®
ACNE '1 line Acne B4 Ret A'	2 history drugs 14 day supply each 180 days history	**Topical Antibiotics** clindamycin erythromycin sulfacetamide/sulfur sulfacetamide	**All Rx benzoyl peroxide products** **Oral Antibiotics** tetracycline minocycline doxycycline	Retin-A® Avita™ Differin®
Proton Pump Inhibitors 'H2 before PPI'	1 history drug 30 day cumulative supply 120 days history	**H2 Antagonists** nizatidine cimetidine famotidine ranitidine		AcipHex® Nexium™ Prevacid® Prilosec® Protonix®
COX-2 'Anti-coagulant or oral corticosteroid or Plavix™ 1st'	**Anticoagulant/ Oral Corticosteroid** 1 history drug 30 day cumulative supply 120 days history		**Anticoagulants** warfarin sodium **Oral Corticosteroids** betamethasone budesonide dexamethasone hydrocortisone hydrocortisone cypionate methylprednisolone prednisolone prednisolone sodium phosphate prednisone triamcinolone triamcinolone diacetate	Celebrex™ (except 400mg)

PROTOCOL	QUALIFIERS	HISTORY DRUG LIST (HDL)		CLAIM DRUG LIST (CDL)
Protopic	**Ages 2-15**	**Medium Potency**	**High Potency**	Protopic®
	2 history drugs	triamcinolone acetonide	fluocinonide	
	(medium/higher potency)	betamethasone valerate	betamethasone dipropionate	
'Must be => 2yo	14 day cumulative supply	fluocinolone acetonide	triamcionlone acetonide	
& use topical cortic 1st'	180 days history	desoximetasone	desoximetasone	
		fluandrenolide	halcinonide/emollient	
	Ages 16 and older	hydrocortisone valerate	amcinonide	
	2 history drugs	fluticasone propionate	halcinonide	
	(medium/higher potency)	hydrocortisone butyrate		
	14 day cumulative supply	mometasone furoate	**Very High Potency**	
	180 days history	hydrocortisone buteprate	diflorasone diacetate	
		clocortolone pivalate	clobetasol propionate	
		prednicarbate	halobetasol propionate	
			betamethasone dipropionate augmented	
Elidel	**Ages 2 and older**	**Medium Potency**	**High Potency**	Elidel®
	2 history drugs	triamcinolone acetonide	fluocinonide	
	(medium/higher potency)	betamethasone valerate	betamethasone dipropionate	
'Must be => 2yo	14 day cumulative supply	fluocinolone acetonide	triamcinolone acetonide	
& use topical cortic 1st'	180 days history	desoximetasone	desoximetasone	
		fluandrenolide	halcinonide/emollient	
		hydrocortisone valerate	amcinonide	
		fluticasone propionate	halcinonide	
		hydrocortisone butyrate		
		mometasone furoate	**Very High Potency**	
		hydrocortisone buteprate	diflorasone diacetate	
		clocortolone pivalate	clobetasol propionate	
		prednicarbate	halobetasol propionate	
			betamethasone dipropionate augmented	

Protocols for ACEs before ARBs are not part of the standard template but are available upon request.

If a Provider submits a claim for a drug in the above chart under the claim drug list (CDL) heading, and the conditions are not met, the claim will reject with:

NDC NOT COVERED SUBOPTIMAL REGIMEN
USE <XXXX> 1ST
MD CALL <XXX-XXX-XXXX> FOR PRIOR AUTHORIZATION

If you receive this message, please discuss the alternatives with the Prescriber. If the Prescriber feels the originally prescribed drug is medically necessary, he or she will need to initiate a request for prior authorization.

A 'qualification period' may also be in place for the CDL drugs. Once an Eligible Person satisfies the Step Therapy requirements, he or she may obtain the CDL drug for a specific time period (e.g. 60 days). When the qualification period has been exceeded, the Eligible Person must requalify for the claim drug by repeating the Step Therapy requirements.

Some Plan Sponsors may choose to give Eligible Persons additional flexibility in choosing not to follow the recommended Step Therapy. A copayment option may be available for some Eligible Persons which allows them to obtain the originally prescribed drug without requiring the Prescriber to call for an override. The Eligible Person may make the decision and obtain the original drug simply by paying a higher copayment.

If this option is in place, claims not meeting the required conditions will reject with:

NDC NOT COVERED SUBOPTIMAL REGIMEN
COPAY = <XX.XX>
TO ACCEPT, SUBMIT PA - 99999999999

If you receive this message, please discuss the alternatives with the Eligible Person and advise that the originally prescribed drug can be obtained by paying the copayment indicated in the message. If the Eligible Person accepts the copayment, resubmit the claim to Caremark using Prior Authorization (PA) code 99999999999.

Exclusive Step Therapy

Exclusive Step Therapy will prevent an Eligible Person from receiving the drug from the claim drug list (CDL) if a drug from the history drug list (HDL) is in the Eligible Person's drug history. The intent of Exclusive Step Therapy is to help prevent an adverse situation occurring resulting from potenially serious interactions between certain drugs.

If Provider submits a claim for a drug from the CDL in an Exclusive Step Therapy protocol, and a drug from the HDL is found in an Eligible Person's history and satisfies all conditions, the Eligible Person will not be able to meet the protocol. The claim will reject with:

<NDC NOT COVERED>

An override option is available by contacting the Help Desk. Please note that a standard template of recommended Exclusive Step Therapy protocols does not exist at this time.

Drug Sampling

Through Caremark, some pharmaceutical manufacturers offer prescription drug-sampling and/or drug-discount programs directed through Providers (i.e., PerformanceScript program). Traditional drug samples are replaced with a PerformanceScript identification card or voucher and must be accompanied by a valid prescription. The temporary identification number on the card or voucher displays the appropriate coding necessary for claim adjudication. Refer to both the front and/or back of the PerformanceScript card or voucher for specific program instructions.

Drug quantity and Patient Pay Amounts may vary and are dependent on program requirements. Provider must remove the identification number and other requirements from the Eligible Person's profile to avoid future claim rejections.

Rebate Programs

Caremark has the right to submit all prescriptions relating to the Provider Agreement to pharmaceutical companies in connection with Caremark's rebate programs and any similar programs. Provider must not submit any of the prescriptions relating to the Provider Agreement to any pharmaceutical company for the purpose of receiving any rebate, discount or the like, except as authorized by Caremark in writing.

Plan Sponsor Programs

Provider must participate in Plan Sponsor programs as requested by Caremark and/or Plan Sponsors. Provider must maintain internal procedures for compliance with such programs and furnish an outline of such procedures to Caremark upon request.

Professional Audit

Inspection Rights

During the term of the Provider Agreement and for two (2) years following termination of the Provider Agreement for any reason, Caremark has the right to audit compliance with the Provider Agreement, including but not limited to, prescriptions for Covered Items for Eligible Persons, U&C submissions, and claims paid to Provider or Eligible Person by Caremark. Caremark has the right to inspect all records of Provider relating to the Provider Agreement.

Audit Types

Caremark's on-line claims processing systems audit every claim concurrently. Retrospective audits may be conducted in the form of a telephone inquiry, investigational audit, or an on-site audit.

Telephone Inquiries

Caremark monitors claims data for reasonableness and potential billing errors on a daily basis. If a discrepancy is found, a representative will contact the Provider via telephone to inquire about, validate and help resolve the discrepancy.

Unless supporting documentation is needed, most of these discrepancies can be validated over the telephone and resolved through a claim reversal and resubmission.

On-site Audits

Caremark also performs routine on-site audits.

Although written notice is not required, Caremark typically will notify Provider approximately two weeks prior to a scheduled audit date.

For an on-site audit, auditors will generally review specific documents and records related to claims paid to Provider by Caremark during the previous 36 months.

Investigational Audits

For an investigational audit, Providers are contacted via telephone or through the mail, and asked to provide photocopies of specific documents and records related to claims paid to Provider or Eligible Person by Caremark during a specified period. Documentation may include, but not be limited to, original prescriptions, signature logs, computer records, and invoices showing purchase or receipt of dispensed medications.

Caremark will identify any discrepancies found in the documentation and request that the Provider review and respond to the discrepancies.

Auditable Documents and Records

Provider will provide Caremark, Plan Sponsors, governmental agencies and/or their representatives or agents access to examine, audit, and copy any and all records deemed by Caremark, in Caremark's sole discretion, necessary to determine compliance with the terms of the Provider Agreement.

Documents and records must be readily accessible at the Dispensing Pharmacy. Auditable documents and records may include, but are not limited to, the following:

- Original prescriptions/scanned images
- Signature logs
- Daily prescription logs
- Wholesaler, manufacturer and distributor invoices
- Refill information
- Prescriber information
- Patient profiles/prescriber orders
- Usual & Customary (U&C) validation

Documents and Records Access

Provider must provide auditor with a clutter free work area, located away from the busiest area of the pharmacy, but with ease of access to the documents and records that are required for the audit.

Provider must maintain proper staffing during an audit to ensure that Provider is reasonably available for questions and the retrieval of information.

Provider authorizes the release of information deemed necessary to determine Provider's compliance with the Provider Agreement to appropriate agencies and parties—including, but not limited to, governmental authorities, third party payers, wholesalers, professional review organizations, and other such parties—as requested by the aforementioned agencies and parties, or by Caremark.